

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-042127

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registered on Form No. 10048 Primary Registration District No. _____ Registrar's No. 7

FILED DEC 12 1962

VS 300
Rev. 4/59

0310
203102

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94201

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Daviess</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gallatin</u>		Length of stay in 1b <u>1 Yr. 10</u>	c. CITY OR TOWN <u>Gallatin</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>East Side Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>---</u>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Alice</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-1883</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Daviess Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>William Osborn</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Reed</u>		14. NAME OF HUSBAND OR WIFE <u>Leslie Dow Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mrs. Ivan Minnick, Lock Spgs. Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>					<u>24 hrs</u>
DUE TO (b) <u>arterial Sclerosis, Cardiac enlargement</u>					<u>3 yrs</u>
DUE TO (c) <u>nephritis, bad senile dementia</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Very bad mental defects, poor eye sight & hearing</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>June 19, 50</u> to <u>Dec 3</u> and last saw ^(her) <u>him</u> alive on <u>Dec. 2 1962</u> . Death occurred at <u>About 4 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>H W Bailey D.D.</u> (Degree or title)			22b. ADDRESS <u>Gallatin Mo</u>		22c. DATE SIGNED <u>Dec 6/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-5-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Centenary Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Gallatin, Missouri</u>	
24. FUNERAL DIRECTOR <u>Hope Funeral Home, Gallatin, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>12-8-62</u>	26. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

DEC 18 1962

Deborah ~~W~~ Reed
12-8-62 # 11a

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed L. Dickerson

Licensed Embalmer No. 3302

P. O. Address Gallatin, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.