

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-045907

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 723

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

10109
20630

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. FILED JAN 2 1963		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Boone</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Maries</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		c. CITY OR TOWN <u>Belle</u>	
Length of stay in lb <u>13 da</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>U. of Missouri med center</u>		d. STREET ADDRESS (If outside, give location) <u>None</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Billy</u> Middle <u>Lee</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>December</u> Day <u>22</u> Year <u>1962</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/9/62</u>
9. AGE (last birthday) <u>13</u>		IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u>	IF UNDER 24 HR Hours <u>13</u> Min. <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Columbia Mo U.M.M.C.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Billy Ray Smith</u>	
13b. MOTHER'S MAIDEN NAME <u>Melba Marie Roberts</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>medical Record, U.M.M.C.</u>		Address <u>None</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>Pneumonia</u>			<u>8 hr</u>
DUE TO (b) <u>Sepsis</u>			<u>8 hr</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Prematurity 31 wks.</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 checked="" 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 _____ a.m. _____ p.m.	Month, Day, Year _____	
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>Dec. 22</u> to <u>Dec 22</u> and last saw her/him alive on <u>Dec 22</u>			
Death occurred at <u>3:15 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Norman Oliver, MD</u>		22b. ADDRESS <u>UMMC - Columbia Mo</u>	22c. DATE SIGNED <u>12-22-62</u>
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Funeral</u>	23b. DATE <u>12/24/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Liberty</u>	23d. LOCATION (City, town, or county) (State) <u>Belle, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Spencer Smith, Columbia, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 23 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>

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 Richard A. Reeves

Licensed Embalmer No. 5109

P. O. Address Columbia 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.