

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-049238

STATE FILE NUMBER

Registration District No. 337 Primary Registration District No. 4496 Registrar's No. 67

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1	1020
2	1020
3	2
4	1
5	0
6	
7	0
8	2
9	94200
10	
11	
12	96-0
13	3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED DEC 19 1962</b>			<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)					
a. COUNTY <b>Shelby</b>			b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Shelbyville</b>			c. CITY OR TOWN <b>Shelbina</b>			d. STREET ADDRESS (If outside, give location) <b>318 South Shelby St.</b>		
b. COUNTY <b>Shelby</b>			Length of stay in 1b <b>42 Days</b>			Inside Limits <b>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></b>			Reside on Farm <b>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></b>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Pleasant Hill Rest. Home</b>			Inside Limits <b>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></b>			d. STREET ADDRESS (If outside, give location) <b>318 South Shelby St.</b>			Reside on Farm <b>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></b>		
3. NAME OF DECEASED (Type or print) <b>Lucile (None) Smith</b>						4. DATE OF DEATH <b>December 15, 1962</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 28, 1880</b>		9. AGE (last birthday) <b>82 y</b>		IF UNDER 1 YEAR <b>Months Days Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and state or country) <b>Shelbina, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Robert Emmett Smith</b>				13b. MOTHER'S MAIDEN NAME <b>Olive Thomas Connely</b>				14. NAME OF HUSBAND OR WIFE <b>None</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Edwin F. Peter, Iowa</b>		Address <b>Des Moines</b>			
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) <b>Arteriosclerotic heart disease -</b>										<b>6 mo.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____											
DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								PART III. If deceased was female was there a pregnancy in last 90 days.			
								<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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>June 1958</u> to <u>present</u> and last saw her <u>alive</u> on <u>Dec 12, 1962</u>											
Death occurred at <u>1:50 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>Chas A. Lightner MD</i> (Degree or title)						22b. ADDRESS <b>Shelbina, Missouri</b>			22c. DATE SIGNED <b>12-17-62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 17, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shelbina Cemetery</b>		23d. LOCATION (City, town, or county) <b>Shelbina, Missouri</b>		(State)			
24. FUNERAL DIRECTOR <b>Hayes Funeral Home, Shelbina, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>12-17-1962</b>		26. REGISTRAR'S SIGNATURE <i>Marianne Simpson</i>					

USE BLACK INK OR TYPEWRITER RIBBON

DEC 21 1962

Received Permit 12-17-62 - MA

**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 Paul E. Hayes  
4461

Licensed Embalmer No. \_\_\_\_\_

P. O. Address Shelbina, Missouri

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.