

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-010253

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 27

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 20 1963

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ATCHISON</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>FAIRFAX</u>		Length of stay in 1b <u>2 DAYS</u>	c. CITY OR TOWN <u>BIGELOW</u>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Community Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>Community Hosp.</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES ALLEN SMITH</u>		4. DATE OF DEATH Month Day Year <u>MARCH 10, 1963</u>	
5. SEX <u>MALE</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>2-26-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>BIGELOW, Mo.</u>
13a. FATHER'S NAME <u>JAMES M. Smith</u>		14. NAME OF HUSBAND OR WIFE <u>MABEL SMITH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, (unknown)) (If yes, give war or dates of <u>No</u>)		16. SOCIAL SECURITY NO. <u>MRS. JAMES DRICKY</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO (b) <u>Acute Bronchopneumonia</u> DUE TO (c) <u>Pneumococcus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		17. INFORMANT <u>MRS. JAMES DRICKY</u> Address <u>8146 MAIN KANSAS CITY, Mo.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>anemia, arteriosclerosis</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 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 1960</u> to <u>Mar 10, 1963</u> and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceasee or title) <u>James Humphrey, M.D.</u>		22b. ADDRESS <u>Mound City, Mo.</u>	
22c. DATE SIGNED <u>2/13/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-13-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT HOPE</u>	23d. LOCATION (City, town, or county) (State) <u>Mound City, Mo.</u>
24. FUNERAL DIRECTOR <u>JAMES H. CRAWFORD</u>		25. DATE RECD. BY LOCAL REG. <u>March 14, 1963</u>	
ADDRESS <u>Mound City, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Therese J. Schaefer</u>	

USE BLACK INK OR TYPEWRITER RIBBON

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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 *J. M. B. [Signature]*

Licensed Embalmer No. 4796

P. O. Address Mount City, 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.