

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-011294  
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2008 Registrar's No. 504  
**FILED APR 9 1963**

DO NOT WRITE ON THIS STUB  
AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Greene</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Length of stay in 1b <b>2 hrs</b>		c. CITY OR TOWN <b>Springfield</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Burge Protestant Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Rt. # 11</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>HARRISON</b> Last <b>SMITH</b>			4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-4-1888</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Road Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Co. Road Dept.</b>		11. BIRTHPLACE (City and state or country) <b>Greene Co., Mo.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>William Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Wilkerson</b>	
14. NAME OF HUSBAND OR WIFE <b>Effie</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of serv) <b>No</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Effie Smith, as Item #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hours</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 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 checked="" 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 <b>March 1963</b> to <b>April 13, 63</b> and last saw him alive on <b>April 13, 1963</b> Death occurred at <b>3:10 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>[Signature]</i>			22b. ADDRESS <b>M. D. Springfield Mo.</b>		22c. DATE SIGNED <b>4-5-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-6-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Smith Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Greene Co., Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Wm. K. Ferrell, Rogersville, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>4-8-63</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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 Wm. K. Terrell

Licensed Embalmer No. 4910

P. O. Address Rogersville, 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.