

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

171  
169  
-63-012308

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 175 Primary Registration District No. 3036 Registrar's No. 169

**FILED APR 5 1963**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Lawrence</b>	a. STATE <b>Mo.</b>	b. COUNTY <b>Lawrence</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Aurora, Mo.</b>	Length of stay in 1b <b>4 Mo.</b>	c. CITY OR TOWN <b>Chesapeake, Mo.</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>Aurora, Community Hospital</b>		d. STREET ADDRESS <b>R.R.</b>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <b>Smith, Melissa</b>	Middle <b>Dollie</b>	Last	Month <b>March</b>	Day <b>25</b>	Year <b>1963</b>

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/5/79</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months Days Hours Min.
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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>//////</b>	11. BIRTHPLACE (City and state or country) <b>Chesapeake</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>William Hicklin</b>	13b. MOTHER'S MAIDEN NAME <b>Luncinda Stogsdill</b>	14. NAME OF HUSBAND OR WIFE <b>Walter L. Smith</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year dates) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address
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18. CAUSE OF DEATH (Enter only one cause)		(INTERVAL BETWEEN ONSET AND DEATH) <b>25 yrs</b> <b>4 mo.</b>
PART I. DEATH WAS CAUSED BY		
IMMEDIATE CAUSE (a) <b>Myocardial Failure</b>	DUE TO (b) <b>Ch. Bronchitis + Bronchectasis</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (c) <b>Rt. Hemiplegia</b>
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 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from 2/17/55 to 3/25/63 and last saw her him alive on 3/23/63  
Death occurred at 5:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Herbert Glover</i>	(Degree or title)	22b. ADDRESS <i>Madison, Mo.</i>	22c. DATE SIGNED <b>3/29/63</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Mar. 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Camp Ground</b>	23d. LOCATION (City, town, or county) <b>Chesapeake Mo.</b>
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24. FUNERAL DIRECTOR <b>Max L. Fossett Funeral Home</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>4/2/63</b>	26. REGISTRAR'S SIGNATURE <i>Clayton Langley</i>
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Max L. Fossett Funeral Home (Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF DOCUMENT

DATE AMENDED	ITEM NO.	SHOULD READ
1 0554		
2 0550		
3		
4 1		
5 2		
6		
7 0		
8 0		
9 526		
10		
11		
12 1-0		
13 1-0		

APR 8 1963

**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 William B. Cantrell

Licensed Embalmer No. 4820

P. O. Address Poplarville, Ms.

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.