

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-023491**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 197

**FILED JUL 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

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Callaway</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Callaway</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fulton</b>		Length of stay in 1b <b>???</b>	c. CITY OR TOWN <b>Fulton</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>307 East 2nd St.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>820 Bluff St.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Prinston</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</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>8/4/1912</b>
10a. USUAL OCCUPATION (Give kind of work done. Working not working (If retired) <b>Hospital Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. NAME OF FATHER'S NAME <b>Joe Smith</b> 13b. MOTHER'S MAIDEN NAME <b>Pearl Robertson</b> 14. NAME OF HUSBAND OR WIFE <b>Veda Marie Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, No war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. [REDACTED] 17. INFORMANT Address <b>State Hospital Records Fulton Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A fall from approximate 53 foot cliff</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Verdict of Jury - He came to his death by accident</b>		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 checked="" 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.) <b>walked away in P.M. of 6/18/63</b>	
20c. TIME OF INJURY Hour <b>Appr. 1</b> Month, Day, Year <b>6/19/63</b>	Mr. Smith was a patient at State Hospital		
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.) <b>Fulton</b>	20f. CITY, TOWN, OR LOCATION <b>Callaway</b>	COUNTY STATE <b>Mo</b>
21. I attended the deceased from <b>Dec 29, 1960</b> to <b>June 19, 1963</b> and last saw her alive on <b>xxx x xxx</b> Death occurred at <b>1:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Denzil C. Browning coroner</b>		22b. ADDRESS <b>Fulton, Mo</b>	22c. DATE SIGNED <b>7/3/63</b>
23a. BURIAL CREMATION, REMOVED (Specify) <b>Burial</b>	23b. DATE <b>June 21, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Newark Mo</b>
24. FUNERAL DIRECTOR <b>Browning Funeral Home, Fulton, Mo</b>		25. DATE RECD. BY LOCAL REG. <b>July 3-1963</b>	26. REGISTRAR'S SIGNATURE <b>Martha Lawrence</b>

JUL 15 1963

JUL 10 1963

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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 Denzil E. Browning

Licensed Embalmer No. 2724

P. O. Address Fullon, Md.

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.