

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-024756**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 315 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB  
AMENDED

VS 300 Rev. 4/59	DATE AMENDED
17000	
27005	
3	
4 1	
5 1	
6	
7 0	
8 0	
9981X	
10	
11	
1291-3	
13 1-0	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Blue</b>		c. CITY OR TOWN <b>Independence</b>	
Length of stay in 1b <b>4yrs</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>Truman Rd. 5/10MI E. 7th</b>		d. STREET ADDRESS (If outside, give location) <b>1813 N. Kiger</b>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Florence</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1963</b>	
5. SEX <b>Female</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>June 18, 1942</b>
9. AGE (last birthday) <b>21</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Atlantic Mills</b>	11. BIRTHPLACE (City and state or country) <b>Caldwell Co, Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Thos. Ezra Stinson</b>	
13b. MOTHER'S MAIDEN NAME <b>Mildred Mattox</b>		14. NAME OF HUSBAND OR WIFE <b>John Smith</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.	
17. INFORMANT <b>Mrs Mildred Stinson Cameron, Mo.</b>		Address	
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>Gun shot wounds of head</b> <b>ad test</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)			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 checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>apparently shot in head</b>	
20c. TIME OF INJURY Hour . Month, Day, Year a.m. p.m. <b>7-363 1 chest</b>	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>at home</b>	20f. CITY, TOWN, OR LOCATION <b>Jackson Mo</b>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <b>Wm C. Howell, M.D., Surgeon</b>		22b. ADDRESS <b>6625 Park St S. Owens</b>	22c. DATE SIGNED <b>7-4-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 6, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Graceland</b>	23d. LOCATION (City, town, or county) (State) <b>Cameron, Mo.</b>
24. FUNERAL DIRECTOR <b>Poland</b>	ADDRESS <b>Cameron, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>7-4-63</b>	26. REGISTRAR'S SIGNATURE <b>Alba L. Craig</b>

100-10000

JUL 22 1963

AUG 1 1963

10000  
10000

1  
1

0  
0

1188

8-18

**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 Henry S. Mitchell

Licensed Embalmer No. 3925

P. O. Address Indep. 910

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.