

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

STATE OF MISSOURI  
**63-032043**

DO NOT WRITE ON THIS STUB      AMENDED

VS 300 Rev. 4/59

1 0417

2 0410

3

4 0

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9 422.1

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11

12 90-0

13 1-0

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Registration District No. 133 Primary Registration District No. 3022 5501 Registrar's No. 108 **63-032043**

**FILED AUG 26 1963**

1. PLACE OF DEATH a. COUNTY <b>Harrison</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission): a. STATE <b>Mo</b> b. COUNTY <b>Harrison</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Washington Twp</b>		Length of stay in 1b <b>62 Yrs</b>	c. CITY OR TOWN <b>10 mi N E of Denver, Mo</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <b>Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rural</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JOSEPH WESLEY SMITH</b>			4. DATE OF DEATH <b>AUG 3, 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>3, 18, 1876</b>
9. AGE (last birthday) <b>87</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>Grain farming</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>SKIRRON SMITH</b>	
13b. MOTHER'S MAIDEN NAME <b>SARAH E. CARR</b>		14. NAME OF HUSBAND OR WIFE <b>EMILY SMITH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>	17. INFORMANT Address <b>Ralph Smith Grant City, Mo</b>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b>			<b>17yrs</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 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>1947</b> to <b>Aug 3, 1963</b> and last saw her/him alive on <b>1aug63</b> Death occurred at <b>2:45 a</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Frank B Matteson M.D.</b> (Degree or title)		22b. ADDRESS <b>Grant City, MO</b>	22c. DATE SIGNED <b>8/4/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug 5, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Harrison Mo</b>
24. FUNERAL DIRECTOR <b>Kermit R Bran</b> ADDRESS <b>Douglas, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>8-21-1963</b>	26. REGISTRAR'S SIGNATURE <b>Zella Maxey</b>	

(Licensed Embalmer's Statement on Reverse Side)

**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 John Andrews, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John Andrews

Licensed Embalmer No. 4211

P. O. Address Grant 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.