

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-033137

STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 313

FILED SEP 12 1963

DO NOT WRITE ON THIS STUB AMENDED

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	SHOULD READ	BY AFFIDAVIT OF
1 0808							
2 0800							
3							
4 1							
5 2							
6							
7 0							
8 2							
9 4200							
10							
11							
12 86-0							
13 1-0							

1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PETTIS</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SEDALIA</u>		c. CITY OR TOWN <u>LA MONTE</u>				
Length of stay in 1b <u>10 DAYS</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SEDALIA REST HOME</u>		d. STREET ADDRESS (If outside, give location) <u>R.F.D # 1</u>				
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED First Middle Last <u>NETTIE PARSONS SMITH</u>			4. DATE OF DEATH Month Day Year <u>9 - 9 - 1963</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1877</u>	9. AGE (last birthday) <u>85</u>	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) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (City and state or country) <u>LAQUAY MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>C. F. PARSONS</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH M. MILLIN</u>		14. NAME OF HUSBAND OR WIFE <u>EDWIN J. SMITH</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>EDWIN J. SMITH, LA MONTE MO</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>						<u>Instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>						<u>16 months</u>
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 checked="" 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 s.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 <u>May 5, 1960</u> to <u>Sept. 9, 1963</u> and last saw her alive on <u>8-28-63</u> Death occurred at <u>8:35 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>T.S. Hopkins, M.D.</u>			22b. ADDRESS <u>1609 S. Lemk Sedalia, Mo.</u>		22c. DATE SIGNED <u>9-10-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-11-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HEBARN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>HEBARN MO</u>		
24. FUNERAL DIRECTOR <u>MOORE FUNERAL HOME</u>		ADDRESS <u>LA MONTE MO</u>		25. DATE RECD. BY LOCAL REG. <u>Sept 10, '63</u>	26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u> <u>Per H. Anderson</u>	

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 Paul M. Moore

Licensed Embalmer No. 3923

P. O. Address Lehigh 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.