

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-034801

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 336 Primary Registration District No. 4494 Registrar's No. 706

STATE FILE NUMBER

FILED AUG 26 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 1010
2 1010
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4 1
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>SHANNON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>SHANNON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WINONA</u>		Length of stay in 1b <u>65 YRS</u>	c. CITY OR TOWN <u>WINONA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mattie Ellen Smith</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>1963</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>12-13-1875</u>	9. AGE (last birthday) <u>77</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Howell County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Jacob Brooks</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Barnett</u>		13c. NAME OF HUSBAND OR WIFE <u>George 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>Leatha Yearwood, Winona, Mo.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTHRITIS DEFORMAS</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 type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>May 1 - 63</u> to <u>Aug 11 - 63</u> and last saw her alive on <u>Aug 7 - 1963</u> Death occurred at <u>6:15 A.M.</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>J. D. Palmer MD</u>			22b. ADDRESS <u>Winona, MO</u>		22c. DATE SIGNED <u>8-14-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>8-13-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Winona, Mo.</u>
24. FUNERAL DIRECTOR <u>CLARY Funeral Home, Winona, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>8-20-1963</u>		26. REGISTRAR'S SIGNATURE <u>Maude Rose</u>

USE BLACK INK OR TYPEWRITER RIBBON

AUG 28 1963

Permit Permit 0000

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 Annita C. Gray

Licensed Embalmer No. 5118

P. O. Address Winona, 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.