

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036921
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 354

FILED OCT 14 1963

1. PLACE OF DEATH a. COUNTY Marion			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Marion		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Length of stay in 1b	c. CITY OR TOWN Hannibal		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Elizabeth Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 3101 St. Marys Avenue Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JEWELL Last SMITH			4. DATE OF DEATH Month September Day 30 Year 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1890	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months 9 Days 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Carrollton Missouri	12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME Edgar Smith		13b. MOTHER'S MAIDEN NAME Almeda Quillan		14. NAME OF HUSBAND OR WIFE Lucille Goodson Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. W.J. Smith Hannibal Missouri		
18. CAUSE OF DEATH (Enter only one cause per line for terminal, and (b) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> Coronary artery disease Heart failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Heart failure</i> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 years
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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 12-15-57 to 9-30-63 and last saw him ^{her} alive on 9-30-63 Death occurred at 11:15 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS M.D. 100 N. Sixth Hannibal, Mo.		22c. DATE SIGNED 10-1-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/2/1963	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION (City, town, or county) (State) Hannibal Missouri		
24. FUNERAL DIRECTOR Smith Funeral Home Hannibal Missouri		25. DATE RECD. BY LOCAL REG. Oct 2, 1963	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 *John L. Ward*

Licensed Embalmer No. 4540

P. O. Address Hannibal Missouri

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.

Permit issued 10/2/63