

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-038476**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2899

**FILED SEP 23 1963**

DO NOT WRITE ON THIS STUB

AMENDED

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Rev. 4/59

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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 <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>JEFFERSON BARRACKS</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
Length of stay in 1b <b>4 DAYS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR VETERANS ADMINISTRATION INSTITUTION <b>HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>2737 FOREST</b>	
3. NAME OF DECEASED (Type or print) First <b>PRINCE</b> Middle <b>ALBERT</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>16</b> Year <b>1963</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-5-15</b>
9. AGE (last birthday) <b>48</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (City and state or country) <b>HUNTINGTON, ARK.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>ANTHONY SMITH</b>		13b. MOTHER'S MAIDEN NAME <b>AMANDA DUPREE</b>	
14. NAME OF HUSBAND OR WIFE -----		16. SOCIAL SECURITY NO. [REDACTED]	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of) <b>YES WW-2</b>		17. INFORMANT Address <b>LITTLE ROCK, ARK.</b> <b>MRS. PARIZDA CAMPBELL, 3224 ARCH ST. LITTLE</b>	
18. CAUSE OF DEATH (Enter only one cause per item) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS, FAR ADVANCED, ACTIVE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>16 MOS.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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>9-12-63</b> to <b>9-16-63</b> and <del>10-16-63</del> Death occurred at <b>6:45 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>George Buffe</i> (Degree or title)		22b. ADDRESS <b>M.D. VA HOSP. JEFF. BRKS. MO.</b>	
22c. DATE SIGNED <b>9-16-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9/17/63</b>	23c. NAME OF CEMETERY OR CREMATORY -----	23d. LOCATION (City, town, or county) (State) <b>Hartford, Arkansas</b>
24. FUNERAL DIRECTOR <b>McConnell Funeral Home, Hartford, Ark.</b>		25. DATE RECD. BY LOCAL REG. <b>9-17-63</b>	26. REGISTRAR'S SIGNATURE <i>John M. [unclear]</i>

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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis

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.