

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043694

STATE FILE NUMBER

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 110

FILED DEC 8 1963

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Howard</u>		a. STATE <u>Missouri</u> COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fayette</u>		c. CITY OR TOWN <u>Franklin</u>	
Length of stay in 1b <u>3 hours</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>Keller Memorial Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>1st Street</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED			4. DATE OF DEATH
First <u>Melvin</u> Middle <u>W.</u> Last <u>Smith, Sr.</u>			Month <u>November</u> Day <u>13</u> Year <u>1963</u>
5. SEX <u>Male</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>Sept. 2, 1905</u>
9. AGE (last birthday) <u>58 yrs</u>		IF UNDER 1 YEAR	IF UNDER 24 HR
		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MKT Railroad</u>	11. BIRTHPLACE (City and state or country) <u>Franklin, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>James William Smith</u>	
13b. MOTHER'S MAIDEN NAME <u>Adelia Norman</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Lee Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Melvin W. Smith Jr. Franklin, Mo.</u>		Address	
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>Coronary occlusion</u>			<u>4 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
DUE TO (b) _____			
DUE TO (c) <u>Emphysema</u>			
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 <u>1960</u> to <u>11/13/63</u> and last saw her/him alive on <u>11/13/63</u>			
Death occurred at <u>4:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. P. Leach M.D.</u>		22b. ADDRESS <u>Fayette, Mo</u>	22c. DATE SIGNED <u>11/30/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 15, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Demetery</u>	23d. LOCATION (City, town, or county) (State) <u>New Franklin, Mo.</u>
24. FUNERAL DIRECTOR <u>Markland Funeral Home</u>		ADDRESS <u>New Franklin, Mo.</u>	DATE RECD. BY LOCAL REG. <u>11-30-63</u>
		26. REGISTRAR'S SIGNATURE <u>Katherine Welch</u>	

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1 0451

2 0450

3 2

4 0

5 2

6

7 0

8 2

9 5271

10

11

12 2-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

14-010-001

DEC 4 1963

Permit board Printing Separate 11-15-63

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 Tom J. Markland

Licensed Embalmer No. 4592

P. O. Address New Franklin, 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.