

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22645

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 788

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 25 years		d. STREET ADDRESS (If rural, give location) 2018 Francis St	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If in hospital or institution, give street address or location) Buchanan Nursing Home 2018 Francis St		d. STREET ADDRESS (If rural, give location) 2018 Francis St	
3. NAME OF DECEASED (Type or Print) a. (First) Aaron Davis Smith b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) 7-5-49
5. SEX Male ()	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 9-8-1878
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME unknown	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE unknown	
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. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Social Security Records St. Joe, Mo
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 15-mos/	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca. of Larynx		DUE TO (b) <input checked="" type="checkbox"/>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <input checked="" type="checkbox"/>		DUE TO (c) <input checked="" type="checkbox"/>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		16-18	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>11/26</u> , 19 <u>48</u> , to <u>6/22</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>6/22/49</u> , 19 <u>49</u> , and that death occurred at <u>10 A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Edward J. Schneider		23b. ADDRESS St. Joseph, Mo. Schneider Bldg	23c. DATE SIGNED 7/12/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-6-49	24c. NAME OF CEMETERY OR CREMATORY Livingston Fun'l Home	24d. LOCATION (City, town, or county) (State) Grand Island, Nebr
DATE REC'D BY LOCAL REG. July 18, 1949	REGISTRAR'S SIGNATURE E. S. Jenkins	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Barry Funeral Home, St. Joseph, Mo	

