

FILED SEP 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31023

State File No. \_\_\_\_\_

6-1 0

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 5720 Registrar's No. 97

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bevier Rural</u>	c. LENGTH OF STAY (In this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bevier Liberty township</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		d. STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED a. (First) <u>George</u> (Type or Print) b. (Middle) <u>Grant</u> c. (Last) <u>Smoot</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>8-23-49</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-11-65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 4 HRS. Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) <u>Keokuk Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE _____
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'S SIGNATURE OR NAME <u>W. Smoot</u> ADDRESS <u>Bevier Mo</u>
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Cistitis</u>		10 years	
DUE TO (c) <u>Chronic Prostatitis</u>		10 years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis</u>		4221	
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) _____ m.	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>8/22/1949</u> , to <u>8/23/1949</u> , that I last saw the deceased alive on <u>8-23, 1949</u> , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Dr. E. W. Widbeck</u> (Degree or title)		23b. ADDRESS <u>Bevier Mo</u>	23c. DATE SIGNED <u>8/23/49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8/23/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Chariton</u>	24d. LOCATION (City, town, or county) (State) <u>Callao RFA Mo</u>
DATE REC'D BY LOCAL REG. <u>9-14-49</u>	REGISTRAR'S SIGNATURE <u>Ruth McNeely</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Edwards</u> ADDRESS <u>Bevier Mo</u>	

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 9/20/49  
MACON Co HEALTH  
COUNTY FILED IN 9/49  
DATE FILED 9/20/49

**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 \_\_\_\_\_  
Student Embalmer

Signed *A. E. Edwards* \_\_\_\_\_

Licensed Embalmer No. *1961* \_\_\_\_\_

P. O. Address *Berwin, 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 this body is not embalmed, fact should be so stated above.