

34733

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 24 1949

| | | | | | | | | |
|--|--|--|--|---|--|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. <u>290</u> | | PRIMARY REG. DIST. NO. <u>4427</u> | | Registrar's No. <u>132</u> | | |
| 1. PLACE OF DEATH a. COUNTY <u>Pulaski</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u> | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Waynesville</u> | | | | c. LENGTH OF STAY (in this place) <u>6 days</u> | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Waynesville General D</u> | | | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Houston</u> | | | | |
| | | | | d. STREET ADDRESS (If rural, give location) _____ | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Evan</u> | | | b. (Middle) _____ | | | c. (Last) <u>Smith</u> | | |
| 4. DATE OF DEATH (Month) (Day) (Year) <u>10 15 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>8/14/1873</u> | | |
| 9. AGE (In years last birthday) <u>76</u> | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 2 HRS. Hours _____ Min. _____ | | | | |
| 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 _____ | | | 11. BIRTHPLACE (State or foreign country) <u>Licking, Missouri D</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | | |
| 13a. FATHER'S NAME <u>Robert Smith</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Martha Parker</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Lella Smith</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME <u>Lella Smith</u> | | ADDRESS <u>Houston 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, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Aneurysm</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arterio-sclerosis</u> DUE TO (c) <u>Hypertension</u> | | | | | 331X | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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>Oct 9</u> , 19 <u>49</u> , to <u>Oct 15</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Oct 15</u> , 19 <u>49</u> , and that death occurred at <u>10:20 a.m.</u> , from the causes and on the date stated above. | | | | | | | | |
| 23a. SIGNATURE <u>[Signature]</u> (Degree or title) _____ | | | | 23b. ADDRESS <u>Waynesville Mo</u> | | 23c. DATE SIGNED <u>10/15/49</u> | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>10-18-49</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Boone Creek Cem</u> | | 24d. LOCATION (City, town, or county) (State) <u>Texas Co. Mo</u> | | |
| DATE REC'D BY LOCAL REG. <u>10-20-49</u> | | REGISTRAR'S SIGNATURE <u>Shelma C. Buckthorn</u> | | 389 25. FUNERAL DIRECTOR'S SIGNATURE <u>Ferguson</u> | | ADDRESS <u>Licking Mo</u> | | |

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

OCT 20 1949

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.

Signed *Embert E. Ferguson*

Signed.....
Student Embalmer

Licensed Embalmer No. *3945*

P. O. Address *Licking 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.