

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43503
State File No.

BIRTH NO. _____ REG. DIST. NO. 355 PRIMARY REG. DIST. NO. 6203 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY TEXAS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY TEXAS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL CURRENT TOWNSHIP		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL 107	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 11 MI. E. RAYMONDVILLE	

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) ICEMS c. (Last) SMITH			4. DATE OF DEATH (Month) (Day) (Year) DEC 15 1949		
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5. SEX MALE		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH 9-16-1858		9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months 2 Days 29		IF UNDER 2 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY L			11. BIRTHPLACE (State or foreign country) DENT CO. MO			12. CITIZEN OF WHAT COUNTRY? USA		
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13a. FATHER'S NAME MARTIN SMITH			13b. MOTHER'S MAIDEN NAME PHOEBIA WELCH			14. NAME OF HUSBAND OR WIFE POLLY SMITH		
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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. L		17. INFORMANT'S SIGNATURE OR NAME ADDRESS THURMAN SMITH RAYMONDVILLE			
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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, asthenia, etc. - It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute Cardio-Respiratory failure						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) Arteriosclerotic Degenerative Decompensative Heart Disease Probable DUE TO (c) Cardio-vascular Renal disease							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None						442X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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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)	
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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?	
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22. I hereby certify that I attended the deceased from Dec 2, 1949, to Dec 10, 1949, that I last saw the deceased alive on Dec 10, 1949, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) D. J. Burns, MD			23b. ADDRESS Houston, Mo.			23c. DATE SIGNED 12/17/49		
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 12-17-49		24c. NAME OF CEMETERY OR CREMATORY NONE		24d. LOCATION (City, town, or county) (State) TEXAS Co. MO	
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DATE REC'D BY LOCAL REG. Dec 23 1949		REGISTRAR'S SIGNATURE Anna Roberts		43. FUNERAL DIRECTOR'S SIGNATURE Gaylord V. Elliott		ADDRESS HOUSTON, MO	
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

1670

Received
Hfas Co.
12-27-
9:00

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 Frank E. Hood

Licensed Embalmer No. 4026

P. O. Address Houston, 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.