

STANDARD CERTIFICATE OF DEATH

FILED JUN 29 1950

State File No.

BIRTH NO. ... REG. DIST. NO. 207 PRIMARY REG. DIST. NO. 4319 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY MARIES		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY MARIES	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BELLE	c. LENGTH OF STAY (In this place) 5 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BELLE	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) RACHEL	b. (Middle) M.	c. (Last) SMITH	4. DATE OF DEATH (Month) (Day) (Year) JUNE 12-1950
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Nov. 17-1869	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Days 6	IF UNDER 24 Hrs. Hours 25
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) MARIES COUNTY*MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME F.A. SHOCKLEY	13b. MOTHER'S MAIDEN NAME AMANDA MATTHEWS	14. NAME OF HUSBAND OR WIFE JAMES H. 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. NONE	17. INFORMANT'S SIGNATURE OR NAME Robert Smith, Belle, Mo.	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		3 Hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		4 to 1
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, advanced		2 yrs.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 6-12, 1950, to 6-12, 1950, that I last saw the deceased alive on 6-12, 1950, and that death occurred at 3:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Pauline Howard, M.D.	23b. ADDRESS Jensenville, Mo.	23c. DATE SIGNED 6-15-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/15/50	24c. NAME OF CEMETERY OR CREMATORY Cambell Cemetery	24d. LOCATION (City, town, or county) (State) MARIES COUNTY*MISSOURI
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DATE REC'D BY LOCAL REG. 6-18-50	REGISTRAR'S SIGNATURE Pauline Howard	FUNERAL DIRECTOR'S SIGNATURE SASSMANN'S FUNERAL SERVICE	ADDRESS BLAND-Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED JUN 26 1930
District Health Officer No. 9,
District File Number

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

Chester Sisson

Licensed Embalmer No. 4178

P. O. Address *Plant - 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.