

FILED AUG 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25931

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 4000 Registrar's No. 212

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Connelville		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Connelville	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home, Connelville, Mo		d. STREET ADDRESS (If rural, give location) None	

3. NAME OF DECEASED (Type or Print) a. (First) Arthur	b. (Middle)	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) Aug. 4 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 2, 1871	9. AGE (In years last birthday) 79	# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours	# UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner	10b. KIND OF BUSINESS OR INDUSTRY Retired Coal Miner	11. BIRTHPLACE (State or foreign country) Clark County, Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Phillip Smith	13b. MOTHER'S MAIDEN NAME Angie Caldwell	14. NAME OF HUSBAND OR WIFE Dora Dixon
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 486-12-7440	17. INFORMANT'S SIGNATURE OR NAME June Peterson, Kirksville, 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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Chronic Valvular Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	11. 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 checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>no</i>	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 _____, 1940, to Aug 4, 1950, that I last saw the deceased alive on Aug 3, 1950, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE <i>J. J. Garrison M.D.</i>	23b. ADDRESS <i>Novinger, Mo.</i>	23c. DATE SIGNED <i>Aug 5-50</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/7/50	24c. NAME OF CEMETERY OR CREMATORY Novinger	24d. LOCATION (City, town, or county) (State) Novinger, Missouri
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DATE REC'D BY LOCAL REG. 8-7-50	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE Paul H. Ray	ADDRESS Kirksville, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

James H. ...

RECEIVED AUG 10 1950
District Health Officer No. 1
District File Number 8-50-132
Date Filed AUG 17 1950

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____

Roy H. ...

Signed _____
Student Embalmer

Licensed Embalmer No. 4432

P. O. Address Kirksville, 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.