

FILED DEC 11 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36748
Registrar's No. 1086

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
d. FULL NAME OF HOSPITAL OR INSTITUTION 934 E. Pythian		d. STREET ADDRESS (If rural, give location) 934 E. Pythian	
3. NAME OF DECEASED (Type or Print) a. (First) Arthur		b. (Middle) E.	
c. (Last) Smith		4. DATE OF DEATH (Month) (Day) (Year) Dec. 6 1950	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH June 20 1878
9. AGE (In years last birthday) 72		10. KIND OF BUSINESS OR INDUSTRY Carpenter	11. BIRTHPLACE (State or foreign country) Cowley Co. Kansas
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Archibald H. Smith		13b. MOTHER'S MAIDEN NAME Elizabeth Griffith	
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. Unknown	
17. INFORMANT'S SIGNATURE OR NAME Frank Smith		ADDRESS Springfield, Mo.	
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) Death By Freezing	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH Unknown	
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.) Home	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Springfield Greene Mo.		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? 133	
22. I hereby certify that I attended the deceased from _____ to _____ that I last saw the deceased _____ on 12-7 , 1950, and that death occurred at 11 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE Handley		23b. ADDRESS Corner 3 Springfield Mo	
23c. DATE SIGNED 12-7-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/9/50	
24c. NAME OF CEMETERY OR CREMATORY Cabool Cemetery		24d. LOCATION (City, town, or county) (State) Cabool, Mo.	
DATE REC'D BY LOCAL REG. 12-9-50		REGISTRAR'S SIGNATURE W.E. Handley MD	
25. FUNERAL DIRECTOR'S SIGNATURE H.H. Lohmeyer		ADDRESS Springfield, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

1396

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 *Lucian J. Swadlow*

Signed.....
Student Embalmer

Licensed Embalmer No. *4875*

P. O. Address *Springfield*

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.