

FILED JAN 13 1951

STANDARD CERTIFICATE OF DEATH

State File No. 41939

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 419

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Dunklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Farmington St. Francois</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Campbell</u>	
c. LENGTH OF STAY (In this place) <u>2yr6mo2da</u>		d. STREET ADDRESS (If rural, give location) <u>Unknown</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>SARA OLIVE</u> b. (Middle) <u>NORA</u> c. (Last) <u>SMITH</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>December 22, 1950</u>
--------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 12, 1910</u>	9. AGE (In years last birthday) <u>40</u> If under 1 year: Months <u>5</u> Days <u>10</u> If under 24 hrs: Hours <u>10</u> Min.
----------------------	-------------------------------	--------------------------------------------------------------------------	------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Townley, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
-----------------------------------------------------------------------------------------------------------------	-----------------------------------	-----------------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME <u>Elias Tuttel</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Elizabeth Cartwright</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Smith</u>
-------------------------------------------	----------------------------------------------------------------	---------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Records, State Hospital No. 4, Farmington, Mo.</u>	ADDRESS
-----------------------------------------------------------------------------------------------------------------------	----------------------------------------	--------------------------------------------------------------------------------------------	---------

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Abt. 1 wk.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Maniacal Exhaustion-</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Psychosis with Mental Deficiency-</u>		<u>Abt. 5 yrs.</u>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>309X</u>

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.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
------------------------------------------	------------------------------------------------------------------------------------------	-------------------------------------------------

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>12:40</u>	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 Dec 6, 1950, to Dec. 22, 1950, that I last saw the deceased alive on Dec. 22, 1950, and that death occurred at 10:40 Am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>John A. Brennan, M.D.</u>	23b. ADDRESS <u>Farmington, State Hospital No. 4, Mo.</u>	23c. DATE SIGNED <u>12-22-50</u>
------------------------------------------------------------------	--------------------------------------------------------------	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Dec. 26, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Vincent Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>R. 2, Campbell, Mo.</u>
------------------------------------------------------------	-----------------------------------	---------------------------------------------------------------	-----------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. <u>Dec 30, 1950</u>	REGISTRAR'S SIGNATURE <u>Ether R. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Landess</u>	ADDRESS <u>Campbell, Mo.</u>
-------------------------------------------------	----------------------------------------------	----------------------------------------------------	---------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

740
2

File No. _____
DISTRICT HEALTH OFFICE No. 4

JAN 8 1951

RECEIVED

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.....
Student Embalmer

Signed

C. A. Cozear

Licensed Embalmer No.

4084

P. O. Address

Farmington

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.