

FILED FEB 14 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 624

BIRTH NO. _____ REG. DIST. NO. 77 PRIMARY REG. DIST. NO. 3016 Registrar's No. 36

1. PLACE OF DEATH a. COUNTY COLE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY OR TOWN JEFFERSON CITY, MO		c. CITY OR TOWN Blackhawk	
c. LENGTH OF STAY (in this place) 4 MONTHS		d. STREET ADDRESS (If rural, give location) 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION WHELAN'S SERVICE CENTER McCARTY		e. CITY OR TOWN 8220	

3. NAME OF DECEASED (Type or Print) a. (First) JOHANA b. (Middle) CATHERINE c. (Last) SMED			4. DATE OF DEATH (Month) (Day) (Year) FEB. 10 1951		
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 14, 1876	9. AGE (In years last birthday) 74	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 100 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HORSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) MINNESOTA		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME HANS HANSEN		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE NEALS C. SMED			
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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 Eugene Drace ADDRESS 402 Coats St.			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		DUE TO (b) Arterial Sclerosis				1 hr	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Had 3 strokes, leg amputation					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						3.31X	

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)	
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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?	
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22. I hereby certify that I attended the deceased from **death when he expired**, 19____, that I last saw the deceased alive on **Feb. 10, 1951**, and that death occurred at **12:30 p.m.**, from the causes and on the date stated above.

23. SIGNATURE J. L. Leslie M.D. Coroner (Degree or title)		23a. ADDRESS Jeff. City Mo		23c. DATE SIGNED 2-10-51	
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24. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Feb. 10/51		24c. NAME OF CEMETERY OR CREMATORY SWEDS BORG		24d. LOCATION (City, town, or county) (State) SWEDSBORG, MISSOURI	
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DATE REC'D BY LOCAL REG. Feb 10-1951		REGISTRAR'S SIGNATURE R.P. Norris MA-MO		68		25. FUNERAL DIRECTOR'S SIGNATURE Bobby Anderson Crocker, MO ADDRESS _____	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 2-13-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 2-13-51

APR 20 1951

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 Walter P. Hedges

Signed
Student Embalmer

Licensed Embalmer No. 4265

P. O. Address St. Louis, 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.