

FILED DEC 31 1951

STANDARD CERTIFICATE OF DEATH

State File No. **41311**BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1095**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give town) Springfield		c. CITY (If outside corporate limits, write RURAL and give township) Springfield, Rural, S. Campbell	
c. LENGTH OF STAY (in this place) 34 Days		d. FULL NAME OF HOSPITAL OR INSTITUTION OSARK OSTEOPATHIC HOSPITAL	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address, box, etc.)		e. STREET ADDRESS (If rural, give location) Route # 9	
3. NAME OF DECEASED a. (First) Julius Ceasear Smith		b. (Middle)	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 12/26/51	
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Aug. 24, 1867
9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months 4 Days 2	IF UNDER 24 HRS. Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Missouri 0		12. CITIZEN OF WHAT COUNTRY? U. S.	
13a. FATHER'S NAME Jerimiah Smith		13b. MOTHER'S MAIDEN NAME Sally Furr	
14. NAME OF HUSBAND OR WIFE Janey Smith			
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 Mrs. Blanche Russell, Rt. # 9		ADDRESS Springfield	
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) Circulatory failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Decompensated hypertension heart failure DUE TO (c) Chronic glomerulonephritis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertrophy of the prostate		19. MAJOR FINDINGS OF OPERATION Transurethral prostatectomy	
19a. DATE OF OPERATION 11/30/51		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 612 X...			
22. I hereby certify that I attended the deceased from 11/22/51 , 19 51 , to 12/26/51 , 19 51 , that I last saw the deceased alive on 12/26 , 19 51 and that death occurred at 1:55 Pm. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Deland E. Wiget DO 2		23b. ADDRESS Springfield, Mo.	
23c. DATE SIGNED 12/26/51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-28-1951	
24c. NAME OF CEMETERY OR CREMATORY Prairie Grove		24d. LOCATION (City, town, or county) (State) Dallas Co. Mo.	
DATE REC'D BY LOCAL REG. 12-28-51		REGISTRAR'S SIGNATURE Edith Williamson	
25. FUNERAL DIRECTOR'S SIGNATURE W. B. Loney		ADDRESS Buffalo Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

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 Ronald B. Jones

Licensed Embalmer No. 7508

P. O. Address Buffalo

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.