

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 349 PRIMARY REG. DIST. NO. 6180 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY Sullivan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Sullivan	
b. CITY (If outside corporate limits, write RURAL and give town or township) OR TOWN North Salem rural		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN North Salem Morris Twp	
d. FULL NAME OF HOSPITAL OR INSTITUTION Morris Twp		d. STREET ADDRESS (If rural, give location) 1050	

3. NAME OF DECEASED (Type or Print) Walter	a. (First)	b. (Middle) George	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) Sept 20 1952
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 19, 1876	9. AGE (In years last birthday) 76	10. UNDER 1 YEAR Months	10. UNDER 1 YEAR Days	10. UNDER 1 YEAR Hours	10. UNDER 1 YEAR Mins.
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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 (City and State or Foreign Country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Benj. F. Smith	13b. MOTHER'S MAIDEN NAME Elizabeth A. Deskins	14. NAME OF HUSBAND OR WIFE Margaret E. Tripp
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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. -----	17. INFORMANT'S SIGNATURE OR NAME Margaret E. Smith	ADDRESS North Salem Mo
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 12 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhages		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Vascular Disease DUE TO (c)		
II. 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)	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) m.	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 Sept 8, 1952, to Sept 20, 1952, that I last saw the deceased alive on Sept 20, 1952, and that death occurred at 1:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE Howard Carter M.D.	(Degree or title)	23b. ADDRESS Browning, Mo.	23c. DATE SIGNED Sept 22, 1952
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 22, 1952	24c. NAME OF CEMETERY OR CREMATORY North Salem Cem.	24d. LOCATION (City, town, or county) (State) North Salem Mo.
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DATE REC'D BY LOCAL REG. Sept 29, 1952	REGISTRAR'S SIGNATURE Laura M. Collett	25. FUNERAL DIRECTOR'S SIGNATURE Wade Funeral Home	ADDRESS Browning, Mo.
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(Licensed Embalmer's Signature) Wade

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

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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

*Gerald L. Wade*

Licensed Embalmer No. 4172

P. O. Address Brownington

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.