

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

496

State File No.

FILED JAN 27 1953

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 24

43
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>CA LEO WAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>FULTON</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>KANSAS CITY MISSOURI</u> <u>3228</u>	
c. LENGTH OF STAY (In this place) <u>34 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>1829 vine 14 53</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>EMERSON STATE HOSPITAL NO 1.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u>		b. (Middle)		c. (Last) <u>SMITH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN * 14 * 53</u>	
5. SEX <u>male</u> <input checked="" type="checkbox"/>		6. COLOR OR RACE <u>colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>		8. DATE OF BIRTH <u>D. K.</u>	
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 1 MIN. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>common laborer</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>D. K.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	

13a. FATHER'S NAME <u>D. K.</u>		13b. MOTHER'S MAIDEN NAME <u>D. K.</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>D. K.</u>		16. SOCIAL SECURITY NO. <u>D. K.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records</u> ADDRESS <u>Fulton Mo.</u>	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypostatic Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Myocarditis</u>		
	DUE TO (c) <u>Arteriosclerosis</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Gastric ulcer.</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 3-1 1946 to 1-14 1953 that I last saw the deceased alive on 1-14 1953 and that death occurred at 12:10 Am., from the causes and on the date stated above.

23a. SIGNATURE <u>Mr. J. Cramer</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>State Hosp #1 Fulton</u>	23c. DATE SIGNED <u>1-19-53</u>
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24a. BURIAL CREMATION (REMOVAL) <u>Buried</u>	24b. DATE <u>1-19-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>State Hosp -</u>	24d. LOCATION (City, town, or county) (State) <u>Fulton Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Jan. 19-1953</u>	REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>	426- <u>426</u>	FUNERAL DIRECTOR'S SIGNATURE <u>C. C. Weeks</u>	ADDRESS <u>Fulton Mo.</u>
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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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.