

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG. 4 - 1953

State File No. **24243**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **75** PRIMARY REG. DIST. NO. **3015** Registrar's No. **69**

1. PLACE OF DEATH a. COUNTY <b>Chilton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution? residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Liberation</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Cameron</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Chillicothe</b> <b>0592</b>	
c. LENGTH OF STAY (in this place) _____		d. STREET ADDRESS (If rural, give location) <b>415 Reymond</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>North Chilton 14404 69</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Fred</b> b. (Middle) <b>Alvin</b> c. (Last) <b>Smith</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 27 53</b>		
5. SEX <b>MO</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>MAY 2 1874</b>	9. AGE (In years last birthday) <b>79</b>	10. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	

13a. FATHER'S NAME <b>Will Smith</b>	13b. MOTHER'S MAIDEN NAME <b>JANE REPTFLEUR</b>	14. NAME OF HUSBAND OR WIFE <b>MAUDE SMITH</b>
--------------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <b>Maude Smith, 415 Reymond</b>
--	-----------------------------------	---

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 <b>7</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocarditis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Possible carcinoma of duodenum 152X</b>		
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 <b>C. B. TOWER</b>	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) <b>CHILICOTHE MO</b>
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 <b>TOWER CO</b>

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

22a. SIGNATURE <b>Ott F. Reisman, D.O.</b> (Degree or title)	22b. ADDRESS <b>Tower Co</b>	22c. DATE SIGNED <b>July 27-53</b>
--	------------------------------	------------------------------------

24a. BURIAL OR CREMATION REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>July 29 - 53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Wheeling Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Wheeling MO</b>
--	-------------------------------	---	--

DATE REC'D BY LOCAL REG. <b>7-31-53</b>	REGISTRAR'S SIGNATURE <b>Winifred W. Moser</b>	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>Funeral Home, Chillicothe Mo.</b>
---	--	---

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

251  
1

NOV 3 1953

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. ....

NOT EMBALMED

Student .....  
Student Embalmer

Signed Robert F. Poland

Licensed Embalmer No. 4277

P. O. Address 321 ... St. ...

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.