

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27581**

FILED SEP 9 - 1953

BIRTH NO. _____		REG. DIST. NO. 1	PRIMARY REG. DIST. NO. 3000	Registrar's No. 282
1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville		c. LENGTH OF STAY (In this place) 6 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville 0613	
d. FULL NAME OF HOSPITAL OR INSTITUTION Kirksville Osteopathic		d. STREET ADDRESS (If rural, give location) 815 S. Franklin		
3. NAME OF DECEASED (Type or Print) a. (First) Sophronia		b. (Middle) Smith	c. (Last) House	4. DATE OF DEATH (Month) (Day) (Year) Sept. 4, 1953
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 9, 1897	9. AGE (In years last birthday) 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher & Secy.		10b. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (State or foreign country) Pike County, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James Smith		13b. MOTHER'S MAIDEN NAME Lucy J. Harris	14. NAME OF HUSBAND XXXXX Ralph W. House	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dr. Ralph W. House, Kirksville	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial failure ANTECEDENT CAUSES metastatic carcinoma DUE TO (b) Mammary adenocarcinoma DUE TO (c) 7 mos II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 6 mos
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		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) 170X	
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?	
22. I hereby certify that I attended the deceased from May 26, 1953 , to Sept 4, 1953 , that I last saw the deceased alive on Sept 4, 1953 , and that death occurred at 5:58 AM. , from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) M T Guttenberg M.D.		23b. ADDRESS Kirksville, Mo.		23c. DATE SIGNED 9-5-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/7/53	24c. NAME OF CEMETERY OR CREMATORY Bowling Green	24d. LOCATION (City, town, or county) (State) Bowling Green, Mo.	
DATE REC'D BY LOCAL REG. 9-5-53	REGISTRAR'S SIGNATURE Kate Lambert	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rudolph Davis Kirksville,		

(Licensed Embalmer's Statement on Reverse Side)

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

OCT 13 1953

MAY 26 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Arnold N. Kugel

Licensed Embalmer No. *4296*

P. O. Address *Perseville*

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.