

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36457**
Registrar's No. **143**

FILED NOV 3 - 1953

BIRTH NO. _____ REG. DIST. NO. **187** PRIMARY REG. DIST. NO. **3090**

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Livingston	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe		c. LENGTH OF STAY (In this place) 14 years	
d. FULL NAME OF HOSPITAL OR INSTITUTION 415 Reynard Street		d. STREET ADDRESS (If rural, give location) 415 Reynard Street	

3. NAME OF DECEASED (Type or Print)	a. (First) Maude	b. (Middle) Mae	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) October 7, 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 30, 1886	9. AGE (In years last birthday) 67	10. UNDER 1 YEAR Months	11. UNDER 2 HRS. Hours	12. UNDER 4 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Linn County, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Reece B. Young	13b. MOTHER'S MAIDEN NAME Anna B. Busby	14. NAME OF HUSBAND OR WIFE Fred A. Smith
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME Floyd L. Smith; Avalon, Missouri	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 Wks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nephritis, Acute Glomerular		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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)
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 **Oct 5**, 19**53**, to **Oct 7**, 19**53** that I last saw the deceased alive on **Oct 7**, 19**53**, and that death occurred at **9 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph G. Conrad M.D.	23b. ADDRESS Chillicothe, Mo.	23c. DATE SIGNED Oct 25 53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-10-53	24c. NAME OF CEMETERY OR CREMATORY Wheeling	24d. LOCATION (City, town, or county) (State) Wheeling, Missouri
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DATE REC'D BY LOCAL REG. Oct 25 1953	REGISTRAR'S SIGNATURE Frances B. Reed	25. FUNERAL DIRECTOR'S SIGNATURE Norman Funeral Home; Chillicothe, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Elton S. Roman

Licensed Embalmer No. 4036

P. O. Address Chillicothe, Missouri.

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.