

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38685**
Registrar's No. **14**

NOV 24 1953

BIRTH NO. _____ REG. DIST. NO. **106** PRIMARY REG. DIST. NO. **4178**

1. PLACE OF DEATH a. COUNTY Dunklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Stoddard	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Holcomb		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bernie	
c. LENGTH OF STAY (If this place) 3 wks.		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Cochran Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) Robert	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1953
-------------------------------------	-------------------------	---------------------------	------------------------	---

5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 6, 1878	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
--------------------	-------------------------------	---	--------------------------------------	---	------------------------	----------------------	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Ret.)	10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (City and State or Foreign Country) Bernie, Mo.	12. COUNTRY OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME Sam Smith	13b. MOTHER'S MAIDEN NAME Mary Furlow	14. NAME OF HUSBAND OR WIFE deceased
-------------------------------------	--	---

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. X X	17. INFORMANT'S SIGNATURE OR NAME Mrs. Effie Green	ADDRESS Bernie, Mo.
--	------------------------------------	---	----------------------------

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 two yrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Nephritis		
	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? 592 X YES <input type="checkbox"/> NO <input 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)
--	--	---

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?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **Bernie, Mo.** **Sept 24, 1953**, that I last saw the deceased alive on **9/24, 1953** and that death occurred at **5 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John E. Cochran M.D.	23b. ADDRESS Holcomb Mo.	23c. DATE SIGNED 9/24/53
--	---------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 9-26-53	24c. NAME OF CEMETERY OR CREMATORY Scycamore cemetery	24d. LOCATION (City, town, or county) (State) Dexter, Mo. R. 1
---	--------------------------	--	---

DATE REC'D BY LOCAL REG. 11/13/53	REGISTRAR'S SIGNATURE J. H. Anderson	25. FUNERAL DIRECTOR'S SIGNATURE Watkins Fun. Ser.	ADDRESS Dexter, Mo.
--	---	---	----------------------------

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

0350

RECEIVED DUNKLIN COUNTY HEALTH

DEPARTMENT 11-16-53

COUNTY FILE NUMBER 1153-278

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 _____

Earl H. Wathens

Student Embalmer No. 489

working under my personal supervision.

Student *Earl H. Wathens*
Student Embalmer

Signed *Walter March Wathens*

Licensed Embalmer No. 4717

P. O. Address *Denton, Mo'*

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.