

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **45718**

FILED JAN 13 1955

DELAYED

BIRTH NO. _____ REG. DIST. NO. **141** PRIMARY REG. DIST. NO. **3025** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY HOWELL		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY HOWELL	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WEST PLAINS,		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN WEST PLAINS, 0461	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 910 W. First	

3. NAME OF DECEASED (Type or Print) a. (First) JANE SMITH b. (Middle) McGHIE c. (Last)	4. DATE OF DEATH 12-19-53
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH 2	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY X	11. BIRTHPLACE (State or foreign country) 4 DENNY LOAN HEAD, SCOTLAND	12. CITIZEN OF WHAT COUNTRY? U S A
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13a. FATHER'S NAME WM. SMITH	13b. MOTHER'S MAIDEN NAME JANE WALKER	14. NAME OF HUSBAND OR WIFE X
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) X	16. SOCIAL SECURITY NO. X	17. INFORMANT'S SIGNATURE OR NAME MARY McGHIE, WEST PLAINS, MO	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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Congestive Heart Failure		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) Senile Dementia		
	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 304X	20. AUTOPSY? YES <input 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 _____, 19____, to _____, 19____, that I last saw the deceased live on **12-19-53**, 19**53**, and that death occurred at **5:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature]	(Degree or title) Mr W	23b. ADDRESS West Plains Mo	23c. DATE SIGNED JAN 6 - 1955
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24a. BURIAL, CREMATION, REMOVAL (Specify) B	24b. DATE 12-21-53	24c. NAME OF CEMETERY OR CREMATORY OAK LAWN	24d. LOCATION (City, town, or county) (State) WEST PLAINS, MO
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DATE REC'D BY LOCAL REG. 1-13-55	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE ROBERTSONS, WEST PLAINS, MO	ADDRESS
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WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

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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 _____

J. S. Roberts

Licensed Embalmer No. 3430

P. O. Address West Plains

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.