

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4136

State File No.

BIRTH NO. FILED MAR 11 1954 REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 176

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived: If institution: residence before admission) a. STATE No. b. COUNTY Butler	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff, rural	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) Route #1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Poplar Bluff Hosp.			

3. NAME OF DECEASED (Type or Print)	a. (First) George	b. (Middle) Grover	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) Feb. 26, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 25, 1884	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Port O Royal, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Henry W. Smith	13b. MOTHER'S MAIDEN NAME Augusta Hammersmith	14. NAME OF HUSBAND OR WIFE Anna Shadle 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)	17. INFORMANT'S SIGNATURE OR NAME Mrs. Anna Smith	ADDRESS Poplar Bluff, Mo.
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute appendicitis		
	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.			5500H

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Approved appendectomy & removal of stomach	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	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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2. I hereby certify that I attended the deceased from Feb 9, 1954, to Feb 26, 1954, that I last saw the deceased alive on Feb 26, 1954, and that death occurred at 11:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) [Signature]	23b. ADDRESS Poplar Bluff, Mo.	23c. DATE SIGNED 3/2/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-1-54	24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	24d. LOCATION (City, town, or county) (State) Poplar Bluff, Mo.
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DATE REC'D BY LOCAL REG. 3/4/54	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Frank-Cotrell	ADDRESS Poplar Bluff, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

MAR 10 1954

BUTLER CO. HEALTH CENTER

FILE No. _____

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 Grove W. Green

Licensed Embalmer No. 2964

P. O. Address Poplar Bluff

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.