

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11899**

FILED MAY 12 1954

BIRTH NO.		REG. DIST. NO. <b>140</b>	PRIMARY REG. DIST. NO. <b>3024</b>	Registrar's No. <b>32</b>
1. PLACE OF DEATH a. COUNTY <b>Lee Hospital Howard Co</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Boone</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Fayette</b>	c. LENGTH OF STAY (In this place) <b>24 hrs</b>	c. CITY OR TOWN <b>Harrisburg</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lee Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>R. R. #1</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Albert</b> b. (Middle) <b>Harrison</b> c. (Last) <b>Smiley</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Apr. 22, 1954</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>11/4/1870</b>	9. AGE (In years last birthday) <b>83</b> IF UNDER 1 YEAR Months <b>5</b> Days <b>18</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>State of Oregon</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13a. FATHER'S NAME <b>Tom Smiley</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Ida Nye</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs A. H. Smiley Harrisburg, Mo</b>
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac decompensation</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>myocardial Infarction</b> DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>10 yrs.</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4201</b>			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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>Jan. 1952</b> , to <b>April 22, 1954</b> , that I last saw the deceased alive on <b>April 22, 1954</b> , and that death occurred at <b>10<sup>00</sup> A.M.</b> , from the causes and on the date stated above.				
23a. SIGNATURE <b>Wm. J. Shaw M.D.</b>		23b. ADDRESS <b>Fayette - Mo.</b>		23c. DATE SIGNED <b>4-26-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>4/25/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Harrisburg Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Harrisburg, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>5-1-54</b>	REGISTRAR'S SIGNATURE <b>Mary S. Shell</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph A. Carr</b>	ADDRESS <b>Fayette, Mo</b>	

WRITE PLAINLY—USING UNFADING 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.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 33

P. O. Address Fayette

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.