

FILED MAY 18 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4052 State File No. **15038**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **4052** Registrar's No. **484**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Agency</b>	c. LENGTH OF STAY (In this place) <b>most of life</b>	c. CITY OR TOWN <b>Agency</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Home, Agency, Mo.</b>		e. STREET ADDRESS (If rural, give location) <b>0 110</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Clara</b> b. (Middle) <b>Barbara</b> c. (Last) <b>Smith</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>May 4, 1954</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>December 1, 1861</b>	9. AGE (In years last birthday) <b>92</b>	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Beatrice, Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>David Kountz</b>	13b. MOTHER'S MAIDEN NAME <b>Helen unknown</b>	14. NAME OF HUSBAND OR WIFE <b>William</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>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. C. H. Farris, Agency, Missouri</b>
17. ADDRESS <b>Agency, Missouri</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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <b>4221</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral thrombosis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>chronic myocarditis + arteriosclerosis</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 <b>no operation</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>no</b>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Agency Buchanan Mo.</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>no injury</b>

22. I hereby certify that I attended the deceased from **May 4, 1954**, to **May 4, 1954**, that I last saw the deceased alive on **May 4, 1954**, and that death occurred at **7:30 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>S. Melaney</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>214. North Patrick Bldg. St. Joseph Mo</b>	23c. DATE SIGNED <b>May 6-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>5/7/1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Agency Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Agency, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>May 11, 1954</b>	REGISTRAR'S SIGNATURE <b>Gather M. Allison</b>	485	25. FUNERAL DIRECTOR'S SIGNATURE <b>Beaton - Bowman</b>	ADDRESS <b>St Joseph Mo.</b>
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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..... Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 319 S. 16th St.

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.