No. 300
10-48

FILED JUN 9 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16968

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 130

1. PLACE OF DEATH
a. COUNTY: Randolph
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moberly
c. LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Whitaker Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Randolph
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moberly
d. STREET ADDRESS (If rural, give location): 1416 Scott Ave.

2883
0

3. NAME OF DECEASED (Type or Print)
a. (First): FRANK
b. (Middle): (NMI)
c. (Last): SMITH

4. DATE OF DEATH (Month) 5 (Day) 29 (Year) 1954

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 3-24-1877
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months 2, Days 5 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Macon, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Benedict Smith
13b. MOTHER'S MAIDEN NAME: Anna Forbes
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME: Raymond Smith — ADDRESS: Kansas City, 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 4222
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-25, 1954, *to* 5-29, 1954, *that I last saw the deceased alive on* 5-28, 1954, *and that death occurred at* 7:40A *m., from the causes and on the date stated above.*

23a. SIGNATURE: E T Whitaker (Degree or title) D.O. 2
23b. ADDRESS: Moberly Mo.
23c. DATE SIGNED: 6-1-54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 5/31/1954
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn
24d. LOCATION (City, town, or county): Macon (State): Mo.

DATE REC'D BY LOCAL REG.: 5/31/54
REGISTRAR'S SIGNATURE: Leah Williams Jones 269
25. FUNERAL DIRECTOR'S SIGNATURE: R. Lester Bram — ADDRESS: Macon, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Signed R Lester Brown

Signed _____
Student Embalmer

Licensed Embalmer No. 4472

P. O. Address Macon, 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.