

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26362**

FILED **JAN 30 1954**  
*aug*

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1917**

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>   |  |
| c. LENGTH OF STAY (in this place) <b>8 Yrs.</b>  |  | d. STREET ADDRESS (If rural, give location) <b>2604 1/2 So. 12th. St.</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>2604 1/2 So. 12th. St.</b>                         |  |  |  |

|                                     |                           |                       |                        |                                       |                     |
|-------------------------------------|---------------------------|-----------------------|------------------------|---------------------------------------|---------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>William</b> | b. (Middle) <b>B.</b> | c. (Last) <b>Smith</b> | 4. DATE OF DEATH (Month) (Day) (Year) | <b>Aug. 18 1954</b> |
|-------------------------------------|---------------------------|-----------------------|------------------------|---------------------------------------|---------------------|

|                    |                               |   |                                      |   |                        |                      |                       |                      |
|--------------------|-------------------------------|---|--------------------------------------|---|------------------------|----------------------|-----------------------|----------------------|
| 5. SEX <b>male</b> | 6. COLOR OR RACE <b>white</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b> | 8. DATE OF BIRTH <b>Sept. 3/1866</b> | 9. AGE (In years last birthday) <b>87</b> | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 2 HRS. Hours | IF UNDER 2 HRS. Min. |
|--------------------|-------------------------------|---|--------------------------------------|---|------------------------|----------------------|-----------------------|----------------------|

|   |  |  |  |
|---|--|--|--|
| 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>farming</b> | 11. BIRTHPLACE (State or foreign country) <b>Clinton Co. Mo.</b> | 12. CITIZEN OF WHAT COUNTRY? <b>USA.</b> |
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|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME <b>Daniel Smith</b> | 13b. MOTHER'S MAIDEN NAME <b>Elizabeth Douglas</b> | 14. NAME OF HUSBAND OR WIFE <b>Widowed</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>Price Smith, Gower, Mo.</b> | ADDRESS |
|--|-------------------------------------|--|---------|

|   |   |  |   |
|---|---|--|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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   |  | INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>carcinoma of urinary bladder</b>  |  |   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>inbedded stone</b><br>DUE TO (c) _____ |  |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |   |

|                              |  |  |
|------------------------------|--|--|
| 19a. DATE OF OPERATION _____ | 19b. MAJOR FINDINGS OF OPERATION _____ | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------------|--|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | 21b. PLACE OF INJURY (e.g., to 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 type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <b>181 X</b> |
|--|--|---|

22. I hereby certify that I attended the deceased from **Oct. 1952**, to **Aug 18, 1954**, that I last saw the deceased alive on **Aug 18, 1954**, and that death occurred at **12.05 P. m.**, from the causes and on the date stated above.

|  |   |                                 |
|--|---|---------------------------------|
| 23a. SIGNATURE <b>W. E. Peman MD</b> (Degree or title) | 23b. ADDRESS <b>423 Main St. Joseph Mo.</b> | 23c. DATE SIGNED <b>8/20/54</b> |
|--|---|---------------------------------|

|   |                            |  |  |
|---|----------------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b> | 24b. DATE <b>8/20/1954</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>Antioch Cemetery</b> | 24d. LOCATION (City, town, or county) (State) <b>Gower Mo.</b> |
|---|----------------------------|--|--|

|  |  |     |  |                          |
|--|--|-----|--|--------------------------|
| DATE REC'D BY LOCAL REG. <b>Aug 24, 1954</b> | REGISTRAR'S SIGNATURE <b>Kathleen M. Allison</b> | 495 | 25. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Murray</b> | ADDRESS <b>Gower Mo.</b> |
|--|--|-----|--|--------------------------|

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 Me

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

John H. Murray

Licensed Embalmer No. ....

2893

P. O. Address

Gower 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.