S. No. 300
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FILED AUG 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26509

BIRTH NO. -- REG. DIST. NO. 52 PRIMARY REG. DIST. NO. 3009 Registrar's No. 60

0161

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

1. PLACE OF DEATH
a. COUNTY: Cape Girardeau
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jackson Mo
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 614 Old Cap Road

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jackson Mo 0161
d. STREET ADDRESS (If rural, give location): 614 Old Cape Road

3. NAME OF DECEASED (Type or Print)
a. (First): Turner
b. (Middle): Lafayette
c. (Last): Smith

4. DATE OF DEATH (Month) (Day) (Year): Aug 15 1954

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec 1-1876
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months 8, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Mill work
11. BIRTHPLACE (City and State or Foreign Country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: John M. Smith
13b. MOTHER'S MAIDEN NAME: Harriet Lenburger
14. NAME OF HUSBAND OR WIFE: Nora Smith

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.: 490-01-3847
17. INFORMANT'S SIGNATURE OR NAME: Nora Smith — ADDRESS: Jackson 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) Thrombosis of the Coronary Arteries

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility
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: 4201
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* Coroner Case, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. F. Sigmund Coroner
23b. ADDRESS: Jackson Mo.
23c. DATE SIGNED: 8/16/54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 17-54
24c. NAME OF CEMETERY OR CREMATORY: Russell Heights
24d. LOCATION (City, town, or county) (State): Jackson Mo

DATE REC'D BY LOCAL REG.: Aug 19-54
REGISTRAR'S SIGNATURE: S G Sims 43-0
25. FUNERAL DIRECTOR'S SIGNATURE: Deneke-Laird — ADDRESS: Jackson Mo

(Licensed Embalmer's Statement on Reverse Side)

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 R. O. Laird

Licensed Embalmer No. 4538

P. O. Address Jackson, 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.