

FILED SEP 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31588**

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 271

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Laclede</b>	
b. CITY OR TOWN <b>Farmington Rural St. Francois</b>		c. CITY OR TOWN <b>Lebanon</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>3Y; 2M; 10das.</b>		e. STREET ADDRESS (If rural, give location) <b>0.537</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri State Hospital No. 4</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>L.</b> b. (Middle) <b>GUS</b> c. (Last) <b>SMITH</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>August 30, 1954</b>
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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>October 21, 1883</b>	9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>9</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teaching and farming</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Laclede County, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Hart Smith</b>	13b. MOTHER'S MAIDEN NAME <b>Annie Jolley</b>	14. NAME OF HUSBAND OR WIFE <b>Kate F. Fulford</b>
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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>Unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Records, State Hospital No. 4, Farmington, Mo.</b>	ADDRESS
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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>3 das.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Lobar pneumonia - - - - -</b>		
	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. <b>Psychosis with cerebral arteriosclerosis.</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>490 X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June 20, 1951 to August 30, 1954, that I last saw the deceased alive on August 30, 1954 and that death occurred at 4:40 p. m., from the causes and on the date stated above.

23a. SIGNATURE <b>J. P. Brennan</b> (Degree or title)	23b. ADDRESS <b>State Hospital No. 4, Farmington, Mo.</b>	23c. DATE SIGNED <b>8-30-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Byrial</b>	24b. DATE <b>Sept. 1, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Lebanon, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>Aug. 30, 1954</b>	REGISTRAR'S SIGNATURE <b>Ether Rudloff</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Palmer Funeral Home, Lebanon, Mo.</b>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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.....

*C. H. Cozart*

Licensed Embalmer No. 408

P. O. Address Farmington

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.