

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4063

FILED MAR 3 1955

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>43</u>		PRIMARY REG. DIST. NO. <u>300.7</u>		Registrar's No. <u>169</u>	
1. PLACE OF DEATH a. COUNTY <u>Butler</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Butler</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Poplar Bluff, Mo.</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>Harvielle,</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Poplar Bluff Hosp.</u>				e. STREET ADDRESS (If rural, give location) <u>Two miles South of Harvielle,</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>A.</u> c. (Last) <u>Smith</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 14, 1955</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 12, 1873</u>	9. AGE (In years last birthday) <u>81</u>	# UNDER 1 YEAR Months <u>4</u> Days <u>2</u>	# UNDER 24 Hrs. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Bent on, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>John Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Winchester</u>		14. NAME OF HUSBAND OR WIFE <u>Eva Snowden Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Eva Smith Harvielle,</u> ADDRESS <u>Mo.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Heart Disease</u>  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 _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) <u>4201</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>2-5</u> , 19 <u>55</u> , to <u>2-14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2-14</u> , 19 <u>55</u> , and that death occurred at <u>5:15 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>M. Hirschman M.D.</u> (Degree or title)				23b. ADDRESS <u>Poplar Bluff, Missouri</u>		23c. DATE SIGNED <u>2-18-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-16-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>City Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Poplar Bluff, Mo.</u>		
DATE REC'D BY LOCAL RES. <u>2/26/55</u>		REGISTRAR'S SIGNATURE <u>(Signature)</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank-Cotrell</u> ADDRESS <u>Poplar Bluff, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
FEB 28 1955  
BUTLER CO. HEALTH CENTER  
FILE No. \_\_\_\_\_

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 Wallace R. Knight

Licensed Embalmer No. 451

P. O. Address 412 5th St  
Poplar Bl

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.