

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

7468

State File No. ....

No. 300  
10-48

**FILED APR 4 1955**

REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 78

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>78</u>		
1. PLACE OF DEATH a. COUNTY <u>Callaway</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Callaway</u>				
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fulton, Mo.</u>		c. LENGTH OF STAY (in this place) <u>54 days</u>		c. CITY OR TOWN <u>McCredie</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>State Hospital #1, Fulton, Mo.</u>				e. STREET ADDRESS (If rural, give location) <u>none</u> <span style="float:right"><u>0149</u></span>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Benjamin</u>			b. (Middle) <u>B.</u>		c. (Last) <u>Smith</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 1, 1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>July 10, 1898.</u>		9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Moke Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Fannie Tarrants</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Records of State Hospital #1, Fulton, Mo.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
<p><i>* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i></p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Starvation, or Inanition</u>						
		ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>						
		DUE TO (b) <u>Patient was Insane, and a Mental Deficient and refused to take nourishment.</u>						
		DUE TO (c) <u>Patient had ulcers and had a recent gastrectomy. (1-12-55) 309 X</u>						
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>								
19a. DATE OF OPERATION <u>1-12-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ulcers. Gastrectomy performed by Dr. John Brown at Callaway Hospital</u>				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>hospital</u>				
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?				
22. I hereby certify that I attended the deceased from <u>Feb. 7, 1955</u> , to <u>Apr. 1, 1955</u> , that I last saw the deceased alive on <u>April 1, 1955</u> , and that death occurred at <u>11 p. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Frank J. Nichols, M.D.</u>				23b. ADDRESS <u>State Hospital #1, Fulton, Mo.</u>				23c. DATE SIGNED <u>4-1-1955</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>APRIL 4/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>		24d. LOCATION (City, town, or county) (State) <u>Callwood Mo</u>			
DATE REC'D BY LOCAL REG. <u>Apr. 2-1955</u>		REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Maupin Funeral Home</u>		ADDRESS <u>Fulton Mo</u>		

(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..

Student.....  
Signature of Student Embalmer

Signed *J. V. Rossini*.....  
Licensed Embalmer No. *285*  
P. O. Address *Milton*.....

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.