

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **821**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1719 Bartlett St.		d. STREET ADDRESS (If rural, give location) 1719 Bartlett St.	

3. NAME OF DECEASED (Type or Print) Edward Smith			4. DATE OF DEATH (Month) (Day) (Year) 7 / 31 / 55		
a. (First)	b. (Middle)		c. (Last)	5. SEX Male	6. COLOR OR RACE Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 4, 1862	9. AGE (In years last birthday) 93	IF UNDER 1 YEAR Months 11	IF UNDER 24 HRS. Hours 27	IF UNDER 24 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Leavenworth, Kansas	
12. CITIZENRY OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME William Smith		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Lula Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Lula Smith ADDRESS 1719 Bartlett St.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION St. Joseph, Mo.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cerebral Hemorrhage		DUPLICATE OF (b) Generalized Arteriosclerosis		Unk.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 331X					
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)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		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 **7/28**, 19**55**, to **7/31**, 19**55**, that I last saw the deceased alive on **7/30**, 19**55**, and that death occurred at **11:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. F. Mundy		23b. ADDRESS 2801 Sacramento St. Joseph, Missouri		23c. DATE SIGNED 8/1/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/3/55		24c. NAME OF CEMETERY OR CREMATORY City Cemetery	
24d. LOCATION (City, town, or county) (State) St. Joseph MO					

DATE REC'D BY LOCAL REG. Aug 8, 1955		REGISTRAR'S SIGNATURE Kathleen M. Allison		25. FUNERAL DIRECTOR'S SIGNATURE Beatrice Gray ADDRESS 812 Pacific St.	
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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
Student Embalmer

Signed

St. J. Chancy

Licensed Embalmer No. *4679*

P. O. Address

St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.