

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22893**  
Registrar's No. **205**

BIRTH NO. **45849-55** REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **304B**

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

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Monroe</b>                     |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>MONROE</b> |  |
| b. CITY OR TOWN <b>HANNIBAL</b>                                  | c. LENGTH OF STAY (in this place) <b>1 day</b> | c. CITY OR TOWN <b>Monroe City</b>   | d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>LEVERING HOSPITAL</b> |  | e. STREET ADDRESS (If rural, give location) <b>410 W. SOMMER ST. 0690</b>  |  |

|  |                               |   |   |  |  |                                |                       |
|--|-------------------------------|---|---|--|--|--------------------------------|-----------------------|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>ALICE</b> b. (Middle) <b>Ruth</b> c. (Last) <b>SMITH</b>    |                               |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>July 16, 1955</b>         |  |  |                                |                       |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>  | 8. DATE OF BIRTH <b>July 15, 1955</b>                                 | 9. AGE (In years last birthday) <b>1</b> | IF UNDER 1 YEAR Months <b>1</b>            | IF UNDER 2 HRS. Hours <b>1</b> | IF UNDER 15 MIN. Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never worked.</b> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/> | 11. BIRTHPLACE (City and State or Foreign Country) <b>HANNIBAL MO</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |                                |                       |

|   |   |   |
|---|---|---|
| 13a. FATHER'S NAME <b>JOSEPH WILLIAM M. SMITH</b>                           | 13b. MOTHER'S MAIDEN NAME <b>Mable C. Montgomery</b>        | 14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>                         |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> | 16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> | 17. INFORMANT'S SIGNATURE OR NAME <b>Joseph W. Smith</b> ADDRESS <b>Monroe City, Mo</b> |

|   |   |  |  |
|---|---|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br><b>2 1/2 HRS</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congenital Heart Disease</b>  |  |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br>DUE TO (c) <b>7544</b> |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |  |

|   |  |  |
|---|--|--|
| 19a. DATE OF OPERATION                          | 19b. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 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 **July 15, 1955** to **July 16, 1955**, that I last saw the deceased alive on **July 16, 1955**, and that death occurred at **12:45 p.m.** from the causes and on the date stated above.

|   |                                 |  |
|---|---------------------------------|--|
| 23a. SIGNATURE <b>F. J. Suttman M.D.</b> (Degree or title)          | 23b. ADDRESS <b>Hannibal Mo</b> | 23c. DATE SIGNED <b>July 16, 55</b>                          |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>             | 24b. DATE <b>7-19-55</b>        | 24c. NAME OF CEMETERY OR CREMATORY <b>ST. JUDES CEMETERY</b> |
| 24d. LOCATION (City, town, or county) (State) <b>Monroe City MO</b> |                                 |  |

|   |   |  |
|---|---|--|
| DATE REC'D BY LOCAL REG. <b>July 18 '55</b> | REGISTRAR'S SIGNATURE <b>Wm. Lucke By Mc Fisher</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>WILSON &amp; SON</b> ADDRESS <b>Monroe City Mo</b> |
|---|---|--|

RECEIVED JUL 22 1955  
MARION CO. HEALTH DEPT  
DATE FILED JUL 22 1955

---

---

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 me..... Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Leslie L. Nelson.....

Licensed Embalmer No. 3119

P. O. Address Marion Co.

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.