

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

22997

State File No. ....

No. 300  
10-48

*Wb. Cochran*  
FILED JUL 27 1955

BIRTH NO. _____		REG. DIST. NO. <u>237</u>		PRIMARY REG. DIST. NO. <u>5820</u>		Registrar's No. <u>7</u>			
1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gideon (Anderson) TWP.</u>		c. LENGTH OF STAY (If in this place) <u>35</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gideon, Rural (Anderson) TWP.</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>				d. STREET ADDRESS (If rural, give location) _____					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Riley</u> b. (Middle) <u>Sherman</u> c. (Last) <u>Smith</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6 26 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>Jan. 4th, 1891</u>		9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 Hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>McNary Co. Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Jake Smith</u>			13b. MOTHER'S MAIDEN NAME <u>Annie Smith</u>		14. NAME OF HUSBAND OR WIFE _____			_____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>999-30-0907</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Roy Smith</u>		ADDRESS <u>Gideon, Mo. Rte # 2</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>Angiographic Clots in Arteries</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Substance Abuse</u> 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 <u>nothing</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE (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>3561</u>		_____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>55</u> , to <u>6/26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/24</u> , 19 <u>55</u> , and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>D.O.</u>				23b. ADDRESS <u>Hokomb, Mo</u>		23c. DATE SIGNED <u>6/28/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-27-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Stonewall Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Portageville, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>7-22-55</u>		REGISTRAR'S SIGNATURE <u>mes F G</u>		451-1		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS _____			

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

0720

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DATE RECEIVED JUL 23 1955  
NEW MADRID CO. HEALTH CENTER  
P. J. S.

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, ~~AAA~~ \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Leopold J. Russell \_\_\_\_\_

Licensed Embalmer No. 509 Ark. \_\_\_\_\_

P. O. Address Piggott, Arkansas \_\_\_\_\_

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