

FILED DEC 19 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40322**

|   |  |  |                       |   |                        |   |   |
|---|--|--|-----------------------|---|------------------------|---|---|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>137</u>  |                       | PRIMARY REG. DIST. NO. <u>4218</u>  |                        | Registrar's No. <u>49</u>   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Henry</u>   |  |  |                       | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u> |                        |   |   |
| b. CITY OR TOWN <u>Windsor</u>  |  | c. LENGTH OF STAY (in this place) <u>9 years</u>   |                       | c. CITY OR TOWN <u>Windsor</u>  |                        | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Windsor Hospital</u>   |  |  |                       | e. STREET ADDRESS (If rural, give location) <u>306 E. Washington</u>  |                        |   |   |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>JACOB</u>  |  |  | b. (Middle) <u>F.</u> |   | c. (Last) <u>SMITH</u> |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Dec. 12, 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>June 18, 1878</u>   |   |
| 9. AGE (In years last birthday) <u>77</u>   |  | 10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Theater operator &amp; owner</u>  |                       | 10b. KIND OF BUSINESS OR INDUSTRY <u>own</u>  |                        | 11. BIRTHPLACE (City and State or Foreign Country) <u>Salineville, Ohio</u>   |   |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 13a. FATHER'S NAME <u>Frederick Smith</u>  |                       | 13b. MOTHER'S MAIDEN NAME <u>Caroline James</u>   |                        | 14. NAME OF HUSBAND OR WIFE <u>Lula Rappert Smith</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<br><u>Mrs. Homer Leaster, Windsor, Mo</u>   |                        |   |   |
| 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, asthenia, etc. It means the disease, injury, or complication which caused death.                           |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cirrhosis of liver</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>5810</u> |                       |   |                        |   |   |
| 19a. DATE OF OPERATION _____  |  | 19b. MAJOR FINDINGS OF OPERATION _____   |                       |   |                        | 20. AUTOPSY? YES <input 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) _____   |                        | 21f. HOW DID INJURY OCCUR _____   |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                       |   |                        |   |   |
| 22. I hereby certify that I attended the deceased from <u>Dec 11, 1955</u> to <u>Dec 12, 1955</u> , that I last saw the deceased alive on <u>Dec 12, 1955</u> , and that death occurred at <u>6:00pm.</u> , from the causes and on the date stated above. |  |  |                       |   |                        |   |   |
| 23a. SIGNATURE (Degree or title) <u>Arnwald M.D.</u>  |  |  |                       | 23b. ADDRESS <u>Windsor mo</u>  |                        | 23c. DATE SIGNED <u>12/15/55</u>  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>   |  | 24b. DATE <u>12-14-55</u>  |                       | 24c. NAME OF CEMETERY OR CREMATORY <u>Laurel Oak</u>  |                        | 24d. LOCATION (City, town, or county) (State) <u>Windsor Missouri</u>   |   |
| DATE REC'D BY LOCAL REG. <u>12-15-55</u>  |  | REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>   |                       | 521 25. FUNERAL DIRECTOR'S SIGNATURE <u>Huston Turner</u>   |                        | ADDRESS <u>Windsor, Mo</u>  |   |

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

RECEIVED  
MAY 10 1958

MAY 4 1956

FEB 4 1959

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 *William M. Turner*

Licensed Embalmer No. *461*

P. O. Address *Amidson*

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.