

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12609

State File No. ....

FILED MAY 15 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 55 PRIMARY REG. DIST. NO. 3011 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before death.) a. STATE <u>Mo.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN <u>Carrollton</u>		c. CITY OR TOWN <u>Carrollton</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>312 N. Monroe</u>		e. STREET ADDRESS (If rural, give location) <u>312 N. Monroe</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>MINNIE</u>	b. (Middle) <u>MILDRED</u>	c. (Last) <u>SMART</u>	(Month) <u>May</u>	(Day) <u>2</u>	(Year) <u>1956</u>
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr. 14, 1886</u>		9. AGE (In years last birthday) <u>70</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas</u>	
12a. FATHER'S NAME <u>James D. Winfrey</u>		12b. MOTHER'S MAIDEN NAME <u>Sarah Jane Housewife</u>		12c. NAME OF HUSBAND OR WIFE <u>Walter Harvey Smart</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		14. SOCIAL SECURITY NO.		15. INFORMANT'S SIGNATURE OR NAME <u>Walter Smart</u> ADDRESS <u>Springfield Mo.</u>	

16. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		17. MEDICAL CERTIFICATION		18. INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Carcinoma of Rectum</u>		II. OTHER SIGNIFICANT CONDITIONS <u>Leukemia Lymphatic</u>		<u>6 mo</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>		<u>2 yrs</u>	
DUE TO (c)					

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 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 1-1, 1956, to May 2, 1956 that I last saw the deceased alive on Apr 30, 1956, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Walter Smart</u> (Degree or title)	23b. ADDRESS <u>Carrollton Mo</u>	23c. DATE SIGNED <u>5/5/56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5/5/56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Wakenda Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Carroll Co. Mo.</u>
DATE REC'D BY LOCAL REG. <u>5/6/56</u>	REGISTRAR'S SIGNATURE <u>Mr. Herbert Calver</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Stanley Gibson</u> ADDRESS <u>Carrollton Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 13 1961

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 Ben W. Gibson

Licensed Embalmer No. 296

P. O. Address Carrollt

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.