

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26720

State File No.

FILED SEP 4 1956

BIRTH NO. _____ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3024 Registrar's No. 23

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

1. PLACE OF DEATH a. COUNTY <u>Howard</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Fayette, Mo.</u>		c. LENGTH OF STAY (In this place) <u>1 Week</u>	c. CITY OR TOWN <u>Harrisburg</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>Lee Hospital</u>			STREET ADDRESS (If rural, give location) <u>1001</u>		
3. NAME OF DECEASED (Type or Print)	a. (First) <u>IDA</u>	b. (Middle) <u>FRANCES</u>	c. (Last) <u>SMILEY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 21, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 23, 1874</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR <u>8</u> Months <u>28</u> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Harrisburg, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Jacob Wirt Nye</u>		13b. MOTHER'S MAIDEN NAME <u>Sophia Gose</u>		14. NAME OF HUSBAND OR WIFE <u>Albert Harrison Smiley</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 <u>Jim Smiley 1385 St Jean, Florissant 21 Mo.</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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Stokes-Adams Syndrome</u> ANTECEDENT CAUSES <u>Hypertension</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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>4 yrs</u> <u>10 yrs</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4330</u>				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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		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 <u>June 1946</u> , to <u>July 21, 1956</u> , that I last saw the deceased alive on <u>July 21, 1956</u> , and that death occurred at <u>12:05 A.M.</u> from the causes and on the date stated above.					
23a. SIGNATURE <u>John G. Shaw M.D.</u> (Degree or title)			23b. ADDRESS <u>Fayette Mo.</u>		23c. DATE SIGNED <u>7-23-56</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>7/23/1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Harrisburg Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Harrisburg Mo.</u>	
DATE REC'D BY LOCAL REG. <u>7-23-56</u>	REGISTRAR'S SIGNATURE <u>Mary K. Shell</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Carr Fayette, Mo.</u>		

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, ~~by~~, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Ralph A. Carr*

Licensed Embalmer No. *331*

P. O. Address *Jayville,*

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.