

Health, Welfare, Public Service
 00-56
 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 From Green

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED NOV 5 - 1956

34796

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 368

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Frankford Mo</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Elizabeth</u> Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>8th St</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Earl</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1892</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Laborer</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	9c. AGE (In years last birthday) <u>74</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	11. BIRTHPLACE (City and state or country) <u>Frankford Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>Mo</u>		13. FATHER'S NAME <u>Henry E. Smith</u>	
14. MOTHER'S MAIDEN NAME <u>unk</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>489-14-7272</u>	
16. SOCIAL SECURITY NO. <u>489-14-7272</u>		17. INFORMANT <u>Frances King Burlington</u> Address <u>Burlington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOSTATIC PNEUMONIA</u> DUE TO (b) <u>DENYDRATION & MALNUTRITION</u> DUE TO (c) <u>CARCINOMA OF LARYNX</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>161x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Hour <u>—</u> Month, Day, Year <u>—</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. CITY, TOWN, OR LOCATION <u>—</u>		COUNTY <u>—</u> STATE <u>—</u>	
21. I attended the deceased from <u>Oct 16, 1956</u> , to <u>Oct 24, 1956</u> and last saw <u>him</u> alive on <u>Oct 24, 1956</u> Death occurred at <u>8:00</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Cornelius Welch, MD</u>		22b. ADDRESS <u>2101 Spruce - Hannibal, Mo</u>	
22c. DATE SIGNED <u>10-26-56</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>	
23b. DATE <u>10-27-56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>	
23d. LOCATION (City, town, or county) <u>Frankford</u>		STATE <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Geo. E. Roberts</u> ADDRESS <u>Hannibal</u>		25. DATE RECD. BY LOCAL REG. <u>10-27-56</u>	
26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Leucke, By W. C. Fisher</u>		27. (Licensed Embalmer's Statement on Reverse Side)	

RECEIVED NOV 2 1956
MARION CO. HEALTH DEPT.
DATE FILED NOV 2 1956

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 *Geo E Roberts*

Licensed Embalmer No *211*

P. O. Address *Hannibal*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.