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Birth, affairs, public service, diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

BE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

FILED DEC 31 1956

THE DEPARTMENT OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40906

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 113

1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Oklahoma</u> b. COUNTY <u>Muskogee</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Muskogee</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital</u>		Length of stay in lb <u>3 mos 3 days</u>		d. STREET ADDRESS (If outside, give location) <u>221 1/2 North 3rd</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>W</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1956</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-24-1892</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>Manager</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Store</u>		11. BIRTHPLACE (City and state or country) <u>Chandler, Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles E. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Weaver</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Not remembered</u>		17. INFORMANT Address <u>VA Hospital records</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>Arteriosclerotic heart disease with hypertrophy left ventricle, decompensated</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____		DUE TO (c) _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
1. <u>Tuberculosis, pulmonary, chronic, far advanced, active</u>						<u>4200A</u>		
2. <u>Pulmonary emphysema</u>								
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 _____ a. m. _____ p. m. _____		<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 _____ STATE _____		
21. <u>99</u> attended the deceased from <u>Aug. 22, 1956</u> to <u>Nov. 24, 1956</u> Death occurred at <u>5:45</u> A. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. <u>Mantell</u> (Degree or title) <u>F. J. MANTELL, M.D., Acting Pathologist</u>				22b. ADDRESS <u>VA Hospital Excelsior Springs, Mo.</u>		22c. DATE SIGNED <u>11-26-56</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>11-27-56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>UNK</u>		23d. LOCATION (City, town, or county) (State) <u>WEST POINT MISSISSIPPI</u>		
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc. Excelsior Springs, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>12/1/56</u>		26. REGISTRAR'S SIGNATURE <u>Baroline Hutchings</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, or by _____, Student Embalmer No. _____ working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed *Ralph E Van Landingham*

Licensed Embalmer No. *40*
Galva Springs Ill
P. O. Address _____

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.