

FILED FEB 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4072

State File No.

BIRTH NO. _____ REG. DIST. NO. 72 PRIMARY REG. DIST. NO. 4134 Registrar's No. 9

1. PLACE OF DEATH a. COUNTY CLAY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY CLAY & CLINTON	
b. CITY (If outside corporate limits, write RURAL and give township) SMITHVILLE, MO.		c. LENGTH OF STAY (If in this place) 25 YRS.	c. CITY OR TOWN SMITHVILLE ⁶⁰⁰⁰
d. FULL NAME OF HOSPITAL OR INSTITUTION SMITHVILLE COMMUNITY HOSP.		No. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) BESSIE MILLER MEEK	a. (First) BESSIE	b. (Middle) MILLER	c. (Last) MEEK	4. DATE OF DEATH JAN. 31, 1957
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN. 25, 1898	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months 0 Days 6	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) CLINTON COUNTY, MO.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME JAMES L. MILLER	13b. MOTHER'S MAIDEN NAME SALLIE ANN BEERY	14. NAME OF HUSBAND OR WIFE ELMER L. MEEK
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ELMER L. MEEK	ADDRESS SMITHVILLE, MO.
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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		INTERVAL BETWEEN ONSET AND DEATH 3 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease		2 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 4200 (STATE) _____
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21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from May 6, 1956, to Jan 31, 1957, that I last saw the deceased alive on Jan 31, 1957, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE Harold R. Cailer M.D.	(Degree or title) M.D.	23b. ADDRESS Smithville, Mo.	23c. DATE SIGNED 2-2-57
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE FEB. 3, '57	24c. NAME OF CEMETERY OR CREMATORY I.O. O.F. CEMETERY	24d. LOCATION (City, town, or county) SMITHVILLE (State) MO.
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DATE REC'D BY LOCAL REG. 2-3-57	REGISTRAR'S SIGNATURE Marguerite Hudgens	25. FUNERAL DIRECTOR'S SIGNATURE McCOMAS FUNERAL HOME	ADDRESS SMITHVILLE, MO.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Donald W. Hanks*.....

Licensed Embalmer No. *45-2*.....

P. O. Address *Smithville, Mo*.....

**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.**