

FILED FEB 19 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4256

STATE FILE NUMBER

6097-57

Registration District No. 116

Primary Registration District No. 3020

Registrar's No. 76

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Franklin</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MISSOURI</u> COUNTY                      |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington</u><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |  | c. CITY OR TOWN <u>INTAN BELLE</u> <sup>0638</sup><br>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. Francis Hosp.</u>   |  | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>                         |   |
| 3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>Rachelle</u> Last <u>Smith</u>  |  | 4. DATE OF DEATH Month <u>Feb</u> Day <u>8</u> Year <u>1957</u>   |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 8 - 1957</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>  | 9. AGE (In years last birthday) <u>X</u> IF UNDER 1 YEAR Months <u>X</u> Days <u>X</u> IF UNDER 24 HRS. Hours <u>6</u> Min. |
| 13. FATHER'S NAME <u>Virgil Smith</u>  |  | 11. BIRTHPLACE (City and state or country) <u>Washington - Mo.</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  | 14. MOTHER'S MAIDEN NAME <u>Jewell Koenig</u>   |   |
| 16. SOCIAL SECURITY NO. <u>-</u>   |  | 17. INFORMANT <u>Virgil Smith - Belle - Mo.</u> Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prima Cerebral Hemorrhage</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Birth Injury</u><br>DUE TO (c) <u>-</u> |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>7600.</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.) |   |   |
| 20c. TIME OF INJURY Hour <u>7:25</u> Month <u>Feb</u> Day <u>8</u> Year <u>1957</u><br>a. m. p. m.   |  |   |   |
| 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.)    | 20f. CITY, TOWN, OR LOCATION  | COUNTY STATE  |
| 21. I attended the deceased from <u>birth</u> to <u>death</u> and last saw her alive on <u>2-8-57</u><br>Death occurred at <u>8:25 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.   |  |   |   |
| 22a. SIGNATURE (Degree or title) <u>Charles P. Schuman M.D.</u>  |  | 22b. ADDRESS <u>Keared Mo</u>   | 22c. DATE SIGNED <u>2-9-57</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE <u>Feb 9 - 1957</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Cemetery</u>  | 23d. LOCATION (City, town, or county) (State) <u>Belle - Mo.</u>  |
| 24. FUNERAL DIRECTOR'S NAME AND ADDRESS <u>Charles Schuman, Belle - Mo.</u>  |  | 25. DATE RECD. BY LOCAL REG. <u>Feb. 12, 1957</u>   | 26. REGISTRAR'S SIGNATURE <u>Charles P. Schuman</u>   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

300  
1-56Health,  
Welfare  
Public  
Service

7-0

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..... *Walter Lassman*

Licensed Embalmer No. *411*

P. O. Address *Blank-1*

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.