

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 14 1957

STATE FILE NUMBER

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Washington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Hickman Mills Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6214 Kingslee		Length of stay in lb 6 yrs	d. STREET ADDRESS (If outside, give location) 6214 Kingslee Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Anna Middle Eldora Last Smith			4. DATE OF DEATH Month 3 Day 5 Year 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1876		9. AGE (In years last birthday) 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Maysville, Missouri		
13. FATHER'S NAME William Merritt			14. MOTHER'S MAIDEN NAME Menecy McBee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Mrs. L.L. Kent, Hickman Mills, Mo.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Decompensation		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertensive Cardiovascular Disease		30 yrs
	DUE TO (c) Arterial Hypertension		
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 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 3:45 Month 3 Day 5 Year 57 a. m. AM 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 HICKMAN MILLS, Mo COUNTY JACKSON STATE MISSOURI
21. I attended the deceased from 3/5/57 3:30 AM to 3/5/57 3:45 AM and last saw her/him alive on 3/5/57 . Death occurred at 3:45 AM m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Deputy or title) Young Howard Clark M.D.	22b. ADDRESS HICKMAN MILLS, Mo	22c. DATE SIGNED 3-5-57

23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	23b. DATE 3-6-57	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
24. FUNERAL DIRECTOR E. N. Georget, Grandview, Mo.		25. DATE RECD. BY LOCAL REG. 3/5/57	26. REGISTRAR'S SIGNATURE Sterling E. Goddard

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

MAR 13 1957

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 *Sterling E. Goodard*

Licensed Embalmer No. *49*

P. O. Address *Grandview*

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.