

FILED MAR 19 1957

STANDARD CERTIFICATE OF DEATH

9659

STATE FILE NUMBER

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. 40

Health,
Welfare
Public
Service300
1-56

All symptoms will be listed. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>0820 PIKE</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bowling Green</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>PIKE Co Hosp.</u>			Length of stay in lb		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) <u>Mollie</u> First <u>Seott</u> Last			4. DATE OF DEATH Month <u>Feb</u> Day <u>22</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</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>1899</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u>08</u> Days <u>14</u> Hours <u>00</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursing the Sick</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>PIKE Co. Mo. U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13. FATHER'S NAME <u>J. Edmond Smith</u>			14. MOTHER'S MAIDEN NAME <u>Don't know</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Mrs. Lelia Johnson</u> Address <u>Bowling Green, Mo.</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>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Uremia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3</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 <u>—</u> Month, Day, Year a. m. <u>—</u> 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 <u>—</u>
20g. STATE <u>—</u>					
21. I attended the deceased from <u>2/28/57</u> to <u>3/1/57</u> and last saw her alive on <u>3/1/57</u> Death occurred at <u>11:40</u> A. M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>M. D. Louisiana, Missouri</u>			22b. ADDRESS <u>—</u>		22c. DATE SIGNED <u>3-1-57</u>
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>	23b. DATE <u>March 19 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bowling Green Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>Bowling Green Mo.</u>	
24. FUNERAL DIRECTOR <u>Grace Bankhead</u>		ADDRESS <u>Bowling Green Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Mar. 14 1957</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	

(Licensed Embalmer's Statement on Reverse Side)

374

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.....
Harold Kinca

Licensed Embalmer No. *457*

P. O. Address *County*

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.