

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 27 1957

18834

STATE FILE NUMBER 4747

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Sebastian		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Fort Smith		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in lb 13 days	STREET ADDRESS (If outside, give location) 1903 N. "J" St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HATTIE Middle MAE Last HOUSLEY			4. DATE OF DEATH Month MAY Day 17 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1906	9. AGE (In years last birthday) 50	
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) Rector, Ark.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Ira H. Russell			14. MOTHER'S MAIDEN NAME Alice Bivot		
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. None	17. INFORMANT Charles L. Housley, Ft. Smith, Ark.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATO RENAL FAILURE DUE TO (b) MITRAL VALVULOTOMY DUE TO (c) MITRAL STENOSIS (RHEUMATIC) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 410 X					INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 2 DAYS 20 YRS.
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.) 410 X			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ 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		STATE
21. I attended the deceased from MAY 4, 1957 to MAY 17, 1957 and last saw her alive on MAY 17, 1957 Death occurred at 10:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>C. P. Vermillion M. D.</i> (Degree or title)			22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 5/17/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5-17-57	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Ft. Smith, Ark.
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. MAY 20 '57		26. REGISTRAR'S SIGNATURE <i>Carl Smith</i>	

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.....

Licensed Embalmer No. 30

P. O. Address St.

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.