

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 10 1957

157 027635
STATE FILE NUMBER 338
3007 Registrar's No.

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 338

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Poplar Bluff, Missouri		c. CITY OR TOWN Quin, Missouri	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE Poplar Bluff Hospital		d. STREET ADDRESS (If outside, give location) Quin, Missouri	
3. NAME OF DECEASED (Type or print) LYDIA KATHERINE SMITH		4. DATE OF DEATH Month July Day 15 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Sept. 26, 1903
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 country) Benton, Arkansas
13a. FATHER'S NAME Lawrence Mangum		13b. MOTHER'S MAIDEN NAME Nora Slidell	14. NAME OF HUSBAND OR WIFE Thomas O. Smith
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. Unknown	17. INFORMANT Thomas O. Smith, Quin, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 2 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			4201
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 _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT <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 June 10, 1957 to 15 July 57 and last saw her/him alive on 15 July 57 Death occurred at 4:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) Norman F. Withers MD		22b. ADDRESS Poplar Bluff Mo	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-17-57	
23c. NAME OF CEMETERY OR CREMATORY Quin Cemetery		23d. LOCATION (City, town, or county) (State) Quin, Missouri	
24. FUNERAL DIRECTOR Landess Funeral Home, Campbell, Mo.		25. DATE RECD. BY LOCAL REG. 9/9/57	
26. REGISTRAR'S SIGNATURE [Signature]			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

23 2 1 5

SEP 10 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 *Christina M. Landes*

Licensed Embalmer No. *4237*

P. O. Address *Campbell*

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.