

with
elfare
blic
rvice

FILED SEP 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30831
STATE FILE NUMBER
Registrar's No. 338

Registration District No. 352 Primary Registration District No. 3004

00
57

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Columbia, Boone, Mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION B. County Hospital		Length of stay in 1b 3 wks	d. STREET ADDRESS 6 miles Southwest
		(If outside, give location)	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Harry	Middle W.	Last Smith	4. DATE OF DEATH	Month 9	Day 14	Year 57
--	-----------------------	---------------------	----------------------	------------------	-------------------	------------------	-------------------

5. SEX Male	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 June 30, 1897	9. AGE (In years last birthday) 60	10. FUNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
-----------------------	----------------------------------	---	--	--	-----------------------------	------------------------------	-------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY farming	11. BIRTHPLACE (City and state or country) Boone County, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
--	---	--	--

13a. FATHER'S NAME Clifford Smith	13b. MOTHER'S MAIDEN NAME Pearl Turner	14. NAME OF HUSBAND OR WIFE Annie Driskill Smith
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes 1919-10-1922	16. SOCIAL SECURITY NO. 486-18-074	17. INFORMANT J. H. Smith	Address Columbia, 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) Pulmonary Embolism		INTERVAL BETWEEN ONSET AND DEATH Immediate
DUE TO (b) PHleboThrombosis		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

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 9 Sept 57 to 14 Sept 57 and last saw ^{her} _{him} alive on 14 Sept 57 Death occurred at 7:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>Shel J. Jones</i>	(Degree or title) MD	22b. ADDRESS 909 Main Ave Columbia Mo	22c. DATE SIGNED 14 Sept 57
--	--------------------------------	---	---------------------------------------

23a. BURIAL CREMATION, REMOVAL (Specify) burial	23b. DATE 9-16-1957	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) Columbia, Missouri
---	-------------------------------	---	--

24. FUNERAL DIRECTOR Lyman Sprinkle	ADDRESS Columbia, Mo.	25. DATE RECD. BY LOCAL REG. Sept 16 1957	26. REGISTRAR'S SIGNATURE Mrs R E Palmer
---	---------------------------------	---	--

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAY 21 1958

SEP 25 1957
SEP 27 1957
SEP 26 1957

NOV 20 1957

OCT 18 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 *[Handwritten Signature]*

Licensed Embalmer No. *4013*
P. O. Address *Columbia*

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.