

FILED JAN 2 1958

STANDARD CERTIFICATE OF DEATH

45335

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 148

V. S. 300
 Rev. 1-57

Securing the medical certificate in this typewrite manner required by §§ 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. No symptoms will be listed. All diseases in Part I must be causally related.

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>MISSOURI</u> b. COUNTY <u>PIKE</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>LOUISIANA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>400-A N. MAIN ST</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>400-A N. MAIN ST</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM CALVIN SMASHEY</u>			4. DATE OF DEATH Month Day Year <u>DEC 23, 1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 1, 1897</u>	9. AGE (In years last birthday) <u>60</u>	10. UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HARDWARE</u>	11. BIRTHPLACE (City and state or country) <u>QUINCY, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>TIMOTHY SMASHEY</u>		13b. MOTHER'S MAIDEN NAME <u>CORA BRIFFITH</u>		14. NAME OF HUSBAND OR WIFE <u>MILDRED BASS SMASHEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY NO. <u>269-09-0436</u>	17. INFORMANT Address <u>MRS. MILDRED SMASHEY, LOUISIANA</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>GUNSHOT WOUND IN HEAD</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>976x</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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 Month, Day, Year 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 _____ to _____ and last saw him ^{her} <u>dead</u> on <u>Dec 23</u> Death occurred at <u>3 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>J. C. Mudd Coroner</u>		22b. ADDRESS <u>Bowling Green Mo</u>		22c. DATE SIGNED <u>Dec 23-57</u>	
23a. BURIAL (CREMATION, REMOVAL) <u>BURIAL</u>	23b. DATE <u>DEC 26 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>LOUISIANA, MO.</u>	
24. FUNERAL DIRECTOR <u>GEO. M. COLLIER, LOUISIANA, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 24, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	

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 *George M. Callier*

Licensed Embalmer No. *3829*

P. O. Address *Louisiana*

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.