

FILED DEC 23 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46940
STATE FILE NUMBER
Registrar's No. 240

Registration District No. 324 Primary Registration District No. 6093

Y. S. 300
ev. 1-57

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1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall Township		c. CITY OR TOWN Cape Girardeau	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri State School		d. STREET ADDRESS (If outside, give location) 915 N. Frederick	
3. NAME OF DECEASED (Type or print) First Roy Middle Chestner Last Smith		4. DATE OF DEATH Month Dec. Day 17, Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1923
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 34 yrs.
13a. FATHER'S NAME Charles Horace Smith		13b. MOTHER'S MAIDEN NAME Mattie Ann Harwood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Records of Mo. State School, Marshall, 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) Myocardial failure		INTERVAL BETWEEN ONSET AND DEATH 17 hrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Chronic Insufficiency		15 yrs	
DUE TO (c) 410XA			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Mental deficiency, low imbecile level, Bil Pulmonary TB		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. (E.g., nature of injury in PART I or PART II of item 18.) Chronic	
20c. TIME OF INJURY Hour _____ 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 Marshall, Missouri	
21. I attended the deceased from Sept., 1955 to Dec., 1957, and last saw ^{him} alive on Dec. 17, 1957 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 <i>[Signature]</i>		22b. ADDRESS Marshall, Missouri	
22c. DATE SIGNED 12-17-57			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12/20/57	23c. NAME OF CEMETERY OR CREMATORY Mo. State School	23d. LOCATION (City, town, or county) (State) Marshall, Missouri
24. FUNERAL DIRECTOR <i>[Signature]</i>		25. DATE RECD. BY LOCAL REG. 12-20-57	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 William Free

Licensed Embalmer No. 4733
P. O. Address Marshall

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.