

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-006950  
STATE FILE NUMBER

FILED MAR 5 - 1958

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 92

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Dexter</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #4</u>			Length of stay in 1b <u>13y, 10m, 8d</u>		d. STREET ADDRESS <u>Route 3</u>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADDIE</u> Middle <u>BELLE</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1958</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 9, 1896</u>		
9. AGE (In years last birthday) <u>61</u>		IF UNDER 1 YEAR Month <u>6</u> Day <u>18</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		11. BIRTHPLACE (City and state or country) <u>Chicago, Illinois</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Gustavus V. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Agnes Wells</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr. no. or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Records, State Hospital #4, Farmington, Mo.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion - - - - - instantaneous.</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease - - - - - Unknown.</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis with mental deficiency.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4200</u>	
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 <u></u> Month, Day, Year a. m. <u></u> p. m. <u></u>		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 COUNTY STATE		
21. I attended the deceased from <u>Feb. 26, 1958</u> to <u>Feb. 27, 1958</u> and last saw her <u>back</u> live on <u>Feb. 27, 1958</u> Death occurred at <u>4:05 A. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>John C. Brennan, M.D.</u>				22b. ADDRESS <u>State Hospital No. 4 Farmington, Missouri</u>		22c. DATE SIGNED <u>2-27-58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Mar. 2, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dexter Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Dexter, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Watkins Funeral Home, Dexter, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Feb. 27, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u>		

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 ..... *Atcozean*

Licensed Embalmer No. *46*

P. O. Address *Farmington*

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.