

Health,
& Welfare
Public
Service

FILED MAY 9 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-015002
STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 141

S. 300
1-57
0644

1. PLACE OF DEATH a. COUNTY <u>Marion</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</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>Residence 201 Dowling</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>201 Dowling</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>EDGAR</u> Last <u>SMASHEY</u>			4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1958</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>July 11, 1887</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>12</u> IF UNDER 24 HRS. Hours <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City of Hannibal</u>	11. BIRTHPLACE (City and state or country) <u>Hannibal Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13a. FATHER'S NAME <u>Robert H. Smashey</u>		13b. MOTHER'S MAIDEN NAME <u>Ruth T. Chadwick</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Ethel Porter Smashey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>487 30 1901</u>	17. INFORMANT Address <u>Mrs. William E. Smashey, Hannibal Missouri</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>Congestive failure</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Myocardial insufficiency</u> DUE TO (c) <u>4222</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years.</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>7:30</u> Month, Day, Year <u>P</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>11-8-57</u> to <u>4-22-58</u> and last saw ^{him} alive on <u>4-22-58</u> . Death occurred at <u>7:30 P</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>W. Crawford Smith M.D.</u>		22b. ADDRESS <u>115 N. 5th St. Hannibal, Mo.</u>		22c. DATE SIGNED <u>4-25-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/26/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>	
24. FUNERAL DIRECTOR <u>W. Crawford Smith, Hannibal Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>4-30-58</u>	26. REGISTRAR'S SIGNATURE <u>W. C. Fisher</u>		

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

RECEIVED MAY 8 1958
MARION CO. HEALTH DEPT.
DATE FILED MAY 8 1958

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 *A Crawford Smith*

Licensed Embalmer No. 3814

P. O. Address Hannibal, Missouri

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.