

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020911
STATE FILE NUMBER

FILED JUN 23 1958 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 264

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo. 0267</u> b. COUNTY <u>Calhoun</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Jefferson City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR UNIVERSITY OF MO. INSTITUTION <u>Medical Center</u>		Length of stay in lb <u>10 Days</u>	d. STREET ADDRESS (If outside, give location) <u>608 Monroe</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Belle</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>58</u>		
5. SEX <u>Female</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 25, 1923</u>	9. AGE (In years last birthday) <u>34</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>part time work - selling warf crys</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>		11. BIRTHPLACE (City and state or country) <u>Owensboro, Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>ARTHUR Mills</u>		13b. MOTHER'S MAIDEN NAME <u>MARY CLARA GIBSON</u>	
14. NAME OF HUSBAND OR WIFE <u>Clifton E Smith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>405-22-3275</u>	
17. INFORMANT <u>Mc. Clifton Smith</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>Pulmonary Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Hypertensive Cardiovascular Disease</u>		<u>4 months</u>	
DUE TO (c) <u>Chronic pyelonephritis</u>		<u>6000</u>		<u>13 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal disease condition given in PART I (a)) <u>Broncho pneumonia; Uremia</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 <u> </u> Day <u> </u> Year <u> </u> 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>6/6/58</u> to <u>6/16/58</u> and last saw her alive on <u>6/14/58</u> Death occurred at <u>11:30 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Diane Burkhardt M.D.</u> (Degree or title)			22b. ADDRESS <u>U. of Missouri Medical Center</u>		22c. DATE SIGNED <u>6/17/58</u>
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE <u>6-19-58</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Longview Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson City Mo.</u>	
24. FUNERAL DIRECTOR <u>Victor Buesch</u> ADDRESS <u>Mo</u>		25. DATE RECD. BY LOCAL REG. <u>June 17, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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

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

Victor Buescher

Licensed Embalmer No.

P. O. Address

3701

J.C. Moore

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.