

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024907  
STATE FILE NUMBER

FILED AUG 14 1958 Registration District No. #67 Primary Registration District No. 6263 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY Christian Co		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo COUNTY Christian	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Linden Twp.		c. CITY OR TOWN Rogersville, Mo	
c. FULL NAME OF HOSPITAL OR INSTITUTION Rogersville, Mo		d. STREET ADDRESS Rogersville, Mo	
Length of stay in 1b 47 yrs		Rt # 2 (If outside, give location)	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Grover C Smith			4. DATE OF DEATH Month Day Year July 29-1958		
5. SEX Male <input type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16-1885	9. AGE (In years last birthday) 73	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Mo	
13. FATHER'S NAME Tom Smith			14. MOTHER'S MAIDEN NAME Sarah Holland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Has No Number		17. INFORMANT Mrs Fern Kauffman, Rogersville, 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) <u>Thrombosis, Coronary, acute</u>			INTERVAL BETWEEN ONSET AND DEATH 2 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis</u>		
	DUE TO (c) <u>4201C</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Histoplasmosis, pulmonary - known 6 mo.</u>			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. (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 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>15 Apr 1955</u> to <u>29 July 1958</u> and last saw <sup>free</sup> him alive on <u>10 July 1958</u> Death occurred at <u>9:55 p m</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>[Signature]</u>	22b. ADDRESS <u>Ozark, Mo</u>	22c. DATE SIGNED <u>4 Aug 1958</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-I-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holland Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Green Co Mo</u>
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24. FUNERAL DIRECTOR <u>T. B. Chaffin</u>	ADDRESS <u>Ozark, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Aug. 7-58</u>	26. REGISTRAR'S SIGNATURE <u>Garnie Day</u>
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(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare Public Service  
220  
300  
1-56  
All symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
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. Coroner cannot certify to a death due to natural causes.

MEDICAL CERTIFICATION

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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..... *T. B. Chaffin* .....

Licensed Embalmer No. *219*

P. O. Address..... *Ozark* .....

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.