

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-026479

STATE FILE NUMBER

49019-52  
FILED JUL 28 1958 Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 308

MEDICAL CERTIFICATION  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 GILLESPIE FUNERAL HOME  
 SEDALIA, MISSOURI  
 Occur, cancer, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
 All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sedalia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Longwood</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bothwell Hosp</b>		Length of stay in lb <b>1 day</b>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GARY</b> Middle <b>WAYNE</b> Last <b>SMITH</b>			4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1958</b>		
5. SEX <b>Male</b> <input type="radio"/>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="radio"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 8, 1958</b>		9. AGE (In years last birthday) Months <b>0</b> Days <b>11</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>*****</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	11. BIRTHPLACE (City and state or country) <b>Sedalia, Missouri</b> <input type="radio"/>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Gerald T. Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Lucille Thomas</b>		14. NAME OF HUSBAND OR WIFE <b>*****</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>*****</b>		16. SOCIAL SECURITY NO. <b>*****</b>	17. INFORMANT Address <b>Gerald T. Smith, Hughesville, Missouri</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 hr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					<b>7630</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <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 <b>7-8-58</b> to <b>7-19-58</b> and last saw <sup>her</sup> him alive on <b>7-19-58</b> Death occurred at <b>8:50 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Alvin J. Lewis M.D.</b> <input type="radio"/>			22b. ADDRESS <b>Sedalia Mo</b>		22c. DATE SIGNED <b>7-21-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 21, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Sedalia, Mo</b>
24. FUNERAL DIRECTOR <b>D. W. Heckart, Sedalia, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>7-22-1958</b>		26. REGISTRAR'S SIGNATURE <b>Frances Shelby</b>

OFFICE OF THE STATE BOARD OF HEALTH  
JANUARY 1944

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 *Russell C. Maag* .....

Licensed Embalmer No. *4804* .....  
P. O. Address *Sedalia, Mo.* .....

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.