

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043333

STATE FILE NUMBER

FILED JAN 12 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1401

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hospital most of life		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1703 St. Joseph Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE MAE SMITH			4. DATE OF DEATH Month Day Year Dec. 27, 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1870
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Illinois
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Tom Wilson	
13b. MOTHER'S MAIDEN NAME Charlette I. McDowell		14. NAME OF HUSBAND OR WIFE W. L. Smith	
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. none	17. INFORMANT Address Mrs. Iva Crawford Bolckow, Missouri
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 331X			INTERVAL BETWEEN ONSET AND DEATH Unk. Unk.
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"/> 2
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 <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>4/6/54</u> to <u>12/27/58</u> and last saw her live on <u>12/26/58</u> Death occurred at <u>4:25a.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Dr. Owen W. D. Craig</i> (Degree or title) 0		22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.	
22c. DATE SIGNED 12/27/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 12/31/1958	23c. NAME OF CEMETERY OR CREMATORY Savannah Cemetery	23d. LOCATION (City, town, or county) (State) Savannah Missouri
24. FUNERAL DIRECTOR Walter Bowman St. Joseph Mo		25. DATE RECD. BY LOCAL REG. Jan 2, 1959	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Goodell</i>

All diseases in Part I must be causally related. NO symptoms with 18-19.

MEDICAL CERTIFICATION
Use ONLY PINK OR RIBBON TYPEWRITE IF POSSIBLE
Dr. Owen W. D. Craig

Willow
Parker Hall

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 *John V. Hennick, Jr.*
Licensed Embalmer No. *4848*
P. O. Address *H. E. No.*

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.