

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044618  
STATE FILE NUMBER

FILED DEC 30 1958

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 606

300  
-57

1. PLACE OF DEATH a. COUNTY <b>JASPER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>JASPER</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>JOPLIN</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>JOPLIN</b> 0495 <sup>0</sup> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MADDOX Nursing Home</b>		Length of stay in lb <b>1 month</b>	d. STREET ADDRESS (If outside, give location) <b>2302 Penn</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>KENNY</b> Middle <b>NELSON</b> Last <b>SMITH</b>			4. DATE OF DEATH Month <b>12</b> Day <b>26</b> Year <b>1958</b>		
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-1877</b>	9. AGE (In years (last birthday)) <b>81</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>TENN.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>MARRION F. SMITH</b>	13b. MOTHER'S MAIDEN NAME <b>SARAH STILLIS</b>	14. NAME OF HUSBAND OR WIFE <b>Aggie Elizabeth Smith</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Oscar N. Smith</b> Address <b>Galena Kan.</b>
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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>Arteriosclerosis + stroke related heart disease generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Prostate hypertrophy</b>		

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.) <b>4500</b>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20c. TIME OF INJURY Hour _____ 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 _____
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21. I attended the deceased from <b>12-26-58</b> , to <b>12-26-58</b> and last saw him alive on <b>12-26-58</b> Death occurred at <b>1:45 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>[Signature]</b> (Degree or title)	22b. ADDRESS <b>2125 Jackson, Joplin, Missouri</b>	22c. DATE SIGNED <b>12/27/58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12-28-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARNHART CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>PURDY MISSOURI</b>
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24. FUNERAL DIRECTOR <b>Roy J. Desfelt</b> ADDRESS <b>Galena Kan.</b>	25. DATE RECD. BY LOCAL REG. <b>12-27-1958</b>	26. REGISTRAR'S SIGNATURE <b>Dorcas Merriam</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Gregory A. Schulte

2125 Johnson - MR 3-7292

3-4474

2333 - Wall

3-6069

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, ~~city~~ ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Roy L. Weisfelt* .....

Licensed Embalmer No. *4945* .....

P. O. Address *Galena, Iowa* .....

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.