

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005083

STATE FILE NUMBER

FILED MAR 4 1959

Registration District No. 111 Primary Registration District No. 5427 Registrar's No. 9

300
1-57

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Boles</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <i>Union</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>US Hiway 66</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>Rt. #2</i>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <i>Varn Billie Smith</i>	4. DATE OF DEATH Month Day Year <i>Feb. 26, 1959</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 26, 1937</i>	9. AGE (In years last birthday) <i>22</i>	IF UNDER 1 YEAR Months Days Hours Min.	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) <i>Stock Clerk</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Ramsey Corp.</i>	11. BIRTHPLACE (City and state or country) <i>Broseley, Mo.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13a. FATHER'S NAME <i>Creslie Smith</i>	13b. MOTHER'S MAIDEN NAME <i>Augusta Miller</i>	14. NAME OF HUSBAND OR WIFE <i>Donna Smith</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>yes</i>	16. SOCIAL SECURITY NO. <i>496-38-5905</i>	17. INFORMANT <i>Donna Smith</i>	Address <i>Rt. 2 Union, Mo.</i>
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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) <i>Fracture mandible, left wrist & left thigh (newly) multiple fractures</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>no cage</i> DUE TO (c) <i>no cage</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (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 checked="" 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.) <i>Subject driving auto which rolled</i>
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20c. TIME OF INJURY Hour Month, Day, Year <i>12:01 a.m. 2/27/59</i>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Highway 66 12 mi east Union</i>	20f. CITY, TOWN, OR LOCATION <i>Union</i>	COUNTY <i>Franklin</i>	STATE <i>Mo</i>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Highway 66 12 mi east Union</i>	20f. CITY, TOWN, OR LOCATION <i>Union</i>	COUNTY <i>Franklin</i>	STATE <i>Mo</i>
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	(Degree or title) <i>MD</i>	22b. ADDRESS <i>Union Mo</i>	22c. DATE SIGNED <i>2/27/59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>March 2, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Richwoods Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Corning, Arkansas</i>
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24. FUNERAL DIRECTOR <i>Casey-Lenox</i>	ADDRESS <i>St. Clair, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>Feb. 27-59</i>	26. REGISTRAR'S SIGNATURE <i>Mary B. Gross</i>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

MAR 13 1963

1959 APR 2 VS
FEB 7 1963

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 K. M. LENOX, JR., Student Embalmer No. 575 working under my personal supervision.

Student K. M. Lenox, Jr.
Signature of Student Embalmer

Signed K. M. Lenox

Licensed Embalmer No. 3601

P. O. Address St. Charles, 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.