

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-006807

STATE FILE NUMBER

FILED FEB 24 1959

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 65

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Elvins</b>		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>Bonne Terre Hosp</b>			Length of stay in lb <b>24 Hours</b>	d. STREET ADDRESS (If outside, give location) <b>210 "A" Street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Amanda</b> Middle <b>(none)</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>14</b> Year <b>1959</b>			
5. SEX <b>Female</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>July 13, 1904</b>	9. AGE (In years last birthday) <b>54</b>	10. F UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (City and state or country) <b>Crawford County, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Wm. G. Turnbaugh</b>			13b. MOTHER'S MAIDEN NAME <b>Martha Crabdree</b>		14. NAME OF HUSBAND OR WIFE <b>Eleck Smith, (Dec)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no., or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Frank Smith, 2208 Cherokee, St. Louis, Mo</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>myocardial infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTES</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic heart Disease</b>						5 years.
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>4200</b>						19. WAS AUTOPSY PERFORMED? <b>2</b> 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>2-8-59</b> to <b>2-14-59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>2-13-59</b> Death occurred at <b>10:00 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>W. Paul Dennis M.D.</b>			22b. ADDRESS <b>Flat River, Mo.</b>		22c. DATE SIGNED <b>2-17-59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/18/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gipson Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Francois County, Mo</b>		(State)	
24. FUNERAL DIRECTOR <b>C.Z. Boyer &amp; Son</b>			ADDRESS <b>Desloge, Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>Feb. 18, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Ethel Rudloff</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

vector, carrier, etc.; must state only standard communicable diseases. All diseases in Part I must be causally related.

MAR 3 1958

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 *B. T. Boyce* .....

Licensed Embalmer No. *3660* .....

P. O. Address *Leesdale, 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.