

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018256

STATE FILE NUMBER

FILED MAY 18 1959

Registration District No. 164 Primary Registration District No. 3032 Registrar's No. 62

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Johnson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Warrensburg</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Warrensburg</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME (If not in hospital or institution) <b>Warrensburg Medical Center</b>		Length of stay in lb <b>69 Yrs</b>	d. STREET ADDRESS (If outside, give location) <b>0572 320 Clark Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Millard Vinson Smith</b>			4. DATE OF DEATH Month Day Year <b>May 12, 1959</b>		
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>Sept. 8, 1889</b>		9. AGE (In years last birthday) <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery Store</b>		11. BIRTHPLACE (City and state or country) <b>Warrensburg, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>William R. Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Mary J. Raines</b>		14. NAME OF HUSBAND OR WIFE <b>Gertrude R. Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>492-14-1228</b>		17. INFORMANT Address <b>Byron Smith- Warrensburg, 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) <u><i>Chr. Interstitial nephritis</i></u>					INTERVAL BETWEEN ONSET AND DEATH <u><i>2 yrs</i></u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u><i>Generalized Arteriosclerosis</i></u>					<u><i>4 yrs</i></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u><i>446X</i></u>					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 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	
21. I attended the deceased from <u><i>1955</i></u> to <u><i>5-12-59</i></u> and last saw him alive on <u><i>5-12-1959</i></u> Death occurred at <u><i>9:00</i></u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u><i>R. Lee Cooper M.D.</i></u>			22b. ADDRESS <u><i>Warrensburg Mo.</i></u>		22c. DATE SIGNED <u><i>5-14-59</i></u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-14-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Warrensburg, Mo.</b>
24. FUNERAL DIRECTOR <b>Sweeney-Phillips-Warrensburg, Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u><i>May 14, 1959</i></u>	26. REGISTRAR'S SIGNATURE <u><i>Savannah Orutehfield</i></u>	

(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.

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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 *J. Earl Priest* .....

Licensed Embalmer No. *3878* .....

P. O. Address *Warrasburg N*

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.