

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018668

STATE FILE NUMBER

187

FILED JUN 1 1959

Registration District No. 274 Primary Registration District No.

Registrar's No.

5. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PETTIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HOUSTONIA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>HOUSTONIA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <u>23 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>0800</u> o Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW JACKSON SMITH</u>			4. DATE OF DEATH Month Day Year <u>MAY 25, 1959</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 19, 1871</u>
9. AGE (In years last birthday) <u>88</u>		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) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>COLE CAMP, MO</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>ANDREW J. SMITH</u>	13b. MOTHER'S MAIDEN NAME <u>MARY JANE SMITH</u>
14. NAME OF HUSBAND OR WIFE <u>ADDIE KENNEDY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>
17. INFORMANT Address <u>MRYTLE HOUGHEN HOUSTONIA, MO</u>		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>Azotemia</u> DUE TO (b) <u>Chronic cardio-renal disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Benign prostatic hypertrophy 442x</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>3 years</u>	
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>9 May '59</u> to <u>16 May '59</u> and last saw her/him alive on <u>16 May '59</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Inscribe or title) <u>Paul R. ... M.D.</u>		22b. ADDRESS <u>Sweet Springs, Mo.</u>	
22c. DATE SIGNED <u>5-26-59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b. DATE <u>MAY 27, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>	
23d. LOCATION (City, town, or county) (State) <u>COLE CAMP, MISSOURI</u>		24. FUNERAL DIRECTOR ADDRESS <u>L.F. PARKER SWEET SPRINGS, MO</u>	
25. DATE RECD. BY LOCAL REG. <u>5/26/1959</u>		26. REGISTRAR'S SIGNATURE <u>Frances Stelby</u>	

JUL 24 1959

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 L. F. Parker

Licensed Embalmer No. 3840

P. O. Address Sweet Springs

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.