

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018747
STATE FILE NUMBER

FILED JUN 10 1959 Registration District No. 290 Primary Registration District No. Registrar's No. 64

300
1-57

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Pulaski | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fort Leonard Wood | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Fort Leonard Wood Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital | | Length of stay in lb -- | d. STREET ADDRESS (If outside, give location) I-51 Lieber Heights Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Melody Middle Kay Last Smith | | | 4. DATE OF DEATH Month May Day 21 Year 1959 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 March 1958 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | 9b. KIND OF BUSINESS OR INDUSTRY ----- | 9. AGE (In years last birthday) 1 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) ----- | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | 11. BIRTHPLACE (City and state or country) Ft Leonard Wood, Mo |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Maxine Smith | |
| 13b. MOTHER'S MAIDEN NAME Barbara L Douglas | | 14. NAME OF HUSBAND OR WIFE ----- | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. --- | 17. INFORMANT Maxine Smith Address Ft Leonard Wood, Missouri |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest | | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) Pneumonia | | | |
| DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 493X |
| 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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20e. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____ | | 20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____ | |
| 21. I attended the deceased from 21 May 59 to 21 May 59 and last saw her ^{her} him alive on 21 May 59 Death occurred at 6:00 P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>H. Baruch</i> H. BARUCH, Capt MC | | 22b. ADDRESS US Army Hospital Ft Leonard Wood, Missouri | |
| 22c. DATE SIGNED 22 May 59 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE May 23 1959 | 23c. NAME OF CEMETERY OR CREMATORY Muscantine Cemetery | 23d. LOCATION (City, town, or county) (State) Muscantine Iowa |
| 24. FUNERAL DIRECTOR HEDGES FUNERAL HOMES INC CROCKER | | 25. DATE RECD. BY LOCAL REG. MO 5-23-59 | 26. REGISTRAR'S SIGNATURE <i>Paula Anderson</i> |

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. 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 *Clarence Thour*

Licensed Embalmer No. *4896*

P. O. Address *Waymole, I*

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.