

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019642

STATE FILE NUMBER

2 5064

FILED JUN 4 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>Green</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis Mo</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Springfield, Mo</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Frisco Hospital</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>2729 N. National</i> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>F</i> Last <i>Smith</i>			4. DATE OF DEATH Month <i>May</i> Day <i>24</i> Year <i>'59</i>
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>8-10-1887</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stationary Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rail Road</i>	11. BIRTHPLACE (City and state or country) <i>Bruno Ark</i>
13a. FATHER'S NAME <i>Andrew Smith</i>		13b. MOTHER'S MAIDEN NAME <i>(Unknown King)</i>	14. NAME OF HUSBAND OR WIFE <i>Lena Moore</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Wife</i> Address <i>Some - 2729 N. National</i>
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>Bulbar Degeneration</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) <i>334x</i>			INTERVAL BETWEEN ONSET AND DEATH
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 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.) <i>No injury</i>	
20c. TIME OF INJURY Hour <i>4:00</i> a.m. Month, Day, Year 1959		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>May 2, 1959</i> to <i>May 24, 1959</i> and last saw ^{her} him alive on <i>May 23, 1959</i> Death occurred at <i>4:00 AM</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Robert W. Ramsey, M.D.</i>		22b. ADDRESS <i>25e S. Florissant Ferguson, Mo</i>	
22c. DATE SIGNED <i>5/24/59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>5-24-59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Local</i>	23d. LOCATION (City, town, or county) (State) <i>Springfield Mo</i>
24. FUNERAL DIRECTOR <i>Albert H. Hoppe</i> ADDRESS <i>1700 Washington</i>		25. DATE RECD. BY LOCAL REG. <i>MAY 24 '59</i>	26. REGISTRAR'S SIGNATURE <i>Lead Smith, M.D.</i>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Elton R. Penick*

Licensed Embalmer No. *4283*
P. O. Address *St. Louis*

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.