

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

59-022474

STATE FILE NUMBER

FILED JUL 14 1959 Registration District No. 292 Primary Registration District No. Registrar's No. 19

1. PLACE OF DEATH a. COUNTY Ralls		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ralls	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN New London		c. CITY OR TOWN New London	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1		d. STREET ADDRESS (If outside, give location) 0870	
3. NAME OF DECEASED (Type or print) Gale Gene Smith		4. DATE OF DEATH Month July Day 8 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH July 19-1947
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country) Hannibal Missouri	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Alfred Newton Smith		13b. MOTHER'S MAIDEN NAME Esther Fay Walkley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Esther Fay Smith	
16. SOCIAL SECURITY NO.		Address New London Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) latent meningitis DUE TO (b) malnutrition DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 3403			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐		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. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT ☐ NOT WHILE WORK ☐	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 Jan 5-5 to July 8 and last saw him alive on July 7 Death occurred at 5:20 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE E. T. Swan D.O.		22b. ADDRESS Perry Mo	
22c. DATE SIGNED 7-9-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-11-1959	23c. NAME OF CEMETERY OR CREMATORY Grand View	23d. LOCATION (City, town, or county) Hannibal Mo.
24. FUNERAL DIRECTOR J. H. Meyers		25. DATE RECD. BY LOCAL REG. 7/10/1959	26. REGISTRAR'S SIGNATURE Clyde C. Mickey

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.

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 *Jane Fields Megaw*

Licensed Embalmer No. *4092*
P. O. Address *Frankford, Md.*

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.