

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023409

STATE FILE NUMBER

FILED JUN 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. 5597

S. 300
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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>4960 Laclede Avenue Frisco Employes Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Oklahoma</u> b. COUNTY <u>Creek</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sapulpa</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Frisco Hospital</u>		Length of stay in lb <u>47 Days</u>	d. STREET ADDRESS (If outside, give location) <u>111 South Elm</u>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle _____ Last <u>Smith</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>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 type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (City and state or country) <u>Pryor, Oklahoma</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13a. FATHER'S NAME <u>Frank Smith</u>	
13b. MOTHER'S MAIDEN NAME <u>Nancy Leak</u>		14. NAME OF HUSBAND OR WIFE <u>Ollie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Nil.</u>	17. INFORMANT <u>Walter Ray Smith, 19B, McArthur Dr.</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>Carcinoma of Brain</u> Sherman, Texas DUE TO (b) <u>metastasis from Lung Ca - Known Sept 1958</u> Left pneumonectomy Sept 1958 DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>163x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-26-59 known</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 _____ a.m. _____ p.m. Month, Day, Year _____		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>Apr 26, 1959</u> to <u>June 11, 1959</u> and last saw her alive on <u>6-10-59</u> Death occurred at <u>6-11-59 3:25A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Norman A. Miller, M.D.</u>	
22b. ADDRESS <u>4960 Laclede Ave</u>		22c. DATE SIGNED <u>6-11-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6-13-59</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or country) (State) <u>Sapulpa, Oklahoma</u>
24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc. 4700 Washington, Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 11 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> M.D.B.

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 H. Remel*

Licensed Embalmer No. *4283*

P. O. Address *St. Louis, Mo.*

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.