

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028318

FILED VS SEP 14 1959/13

REG. NO. 11034 Registration District No. 3007 Registrar's No. 464

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CARTER</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Length of stay in 1b <b>39 DAYS</b>	c. CITY OR TOWN <b>ELLSINORE</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADM. HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <b>NONE</b> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>DENEY</b> Last <b>SMITH</b>			4. DATE OF DEATH <b>AUGUST 26, 1959</b> Month Day Year		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11-6-98</b>	9. AGE (last birthday) <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	11. BIRTHPLACE (City and state or country) <b>MILL SPRINGS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>JOHN T. SMITH</b>		13b. MOTHER'S MAIDEN NAME <b>REBECCA LEACH</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>YES WWII</b>		16. SOCIAL SECURITY NO. <b>702165883</b>		17. INFORMANT <b>VA HOSPITAL RECORDS, POPLAR BLUFF MO.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA, RIGHT UPPER LUNG.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 Months.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
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
<b>YAN, POPLAR BLUFF MO.</b>		<b>7/18/59</b>		<b>8/26/59</b>	
21. attended the deceased from _____ to _____ Death occurred at <b>2:45 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Robert S. Cohen</b> (Name or title) <b>ROBERT S. COHEN, M.D., Chief, Med. Svc., VA HOSPITAL, POPLAR BLUFF, MO.</b>			22b. ADDRESS		22c. DATE SIGNED <b>8/28/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>	<b>Aug 28-59</b>	<b>Garrison Hill</b>		<b>Way Mill Spring, Mo.</b>	
24. FUNERAL DIRECTOR <b>Dick Funeral Home</b> ADDRESS <b>Medmont</b>		25. DATE RECD. BY LOCAL REG. <b>9/13/59</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 14 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

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Marvin E. Bowler

Licensed Embalmer No. 4426

P. O. Address Piedmont

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con- 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.