URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS DEC 15 1959

59-038816

STATE FILE NUMBER

ENDED

Registration District No. 4 Primary Registration District No. _____ Registrar's No. 117

1. PLACE OF DEATH
a. COUNTY Atchison
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fairfax Mo
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Fairfax hospital
Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Atchison
c. CITY OR TOWN Rock-Port Mo
Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Josie Middle: Tasker Last: Smith

4. DATE OF DEATH Month: Nov Day: 30 Year: 1959

5. SEX F

6. COLOR OR RACE W

7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐

8. DATE OF BIRTH Nov. 13 1873

9. AGE (last birthday) 86

IF UNDER 1 YEAR Months 0 Days 17

IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress making

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) Ind

12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME Benjamin Conrad

13b. MOTHER'S MAIDEN NAME Amanda Flackman

14. NAME OF HUSBAND OR WIFE Stuart Smith (deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Dolly Smith
Address Rock-Port Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 days.

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)
Intertrochanteric fracture left hip.

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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 WORK ☐ NOT WHILE AT 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 Nov 29, 59, to Nov 30-59 and last saw her/him alive on 11-11-59
Death occurred at 6:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Wallace Carpenter (Degree or title) MD

22b. ADDRESS Rock Port Mo

22c. DATE SIGNED 12-4-59

23a. BURIAL, CREMATION, REMOVAL (Specify) burial

23b. DATE Dec. 3-59

23c. NAME OF CEMETERY OR CREMATORY Elmwood cemetery

23d. LOCATION (City, town, or county) Rock-Port (State) Mo

24. FUNERAL DIRECTOR Bertram Funeral Home

ADDRESS Rock-Port Mo

25. DATE RECD. BY LOCAL REG. Dec 12, 1959

26. REGISTRAR'S SIGNATURE Marvin H. Schaeler

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by n

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed C E Burham

Signature of Student Embalmer

Licensed Embalmer No 1764

P. O. Address Box 1 Port

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