

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039129**

FILED VS DEC 7 1959

STATE FILE NUMBER

Registration District No. 46 Primary Registration District No. 4066 Registrar's No. 374

MAILED

1. PLACE OF DEATH a. COUNTY <b>Caldwell</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Platt</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kingston</b>		Length of stay in 1b	c. CITY OR TOWN <b>Parkville</b>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Berry Rest Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>207 Main St.</b>
			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Jessie</b> Middle <b>Myrtle</b> Last <b>Brown</b>			4. DATE OF DEATH Month <b>Oct</b> Day <b>28</b> Year <b>1959</b>			
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8-10-1879</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours	IF UNDER 24 HR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor (ret)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Dress Shop</b>	11. BIRTHPLACE (City and state or country) <b>Lineville Iowa</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>George W Smith</b>	13b. MOTHER'S MAIDEN NAME <b>EMMA A Keller</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>478-09-7570A</b>	17. INFORMANT <b>Mrs Lucele Hughes, Parkville, Mo.</b>
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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>Cerebral Vascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Arteriosclerotic C.V. disease &amp;</b>	} <b>5 years.</b>
	DUE TO (c) <b>Cerebral fracture</b>	
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 checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year
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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 <b>Kingston Caldwell Mo</b>	COUNTY	STATE
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21. I attended the deceased from **Sept 1 1959** to **Oct 28 1959** and last saw her <sup>her</sup> alive on **10-28-59**.  
Death occurred at **10:30 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Frank R. Daley MD</b>	(Degree or title)	22b. ADDRESS <b>Hamilton, Mo.</b>	22c. DATE SIGNED <b>10-30-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-30-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Seymour, Iowa.</b>	23d. LOCATION (City, town, or county) <b>Seymour, Iowa.</b>	(State)
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24. FUNERAL DIRECTOR <b>Cramer Clark</b>	ADDRESS <b>Kingston, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>11-30-59</b>	26. REGISTRAR'S SIGNATURE <b>Gladys Jones</b>
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DOCUMENT

MEDICAL CERTIFICATION

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

~~\_\_\_\_\_~~

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Cramer Clark

Licensed Embalmer No. 3257  
P. O. Address Kingston

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