

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'59 0 4 3 3 5 1

FILED VS JAN - 4 1960

Registration District No. 37 Primary Registration District No. 4044 STATE FILE NUMBER Registrar's No. 57

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sturgeon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sturgeon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sturgeon, Missouri</u>		Length of stay in 1b <u>lifetime</u>	d. STREET ADDRESS <u>Sturgeon, Missouri</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kirtley Miller Smith</u>			4. DATE OF DEATH Month Day Year <u>Dec. 27, 1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1877</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months Day Hours Min. <u>7 11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Audrain County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Joseph D. Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Belle Miller</u>		14. NAME OF HUSBAND OR WIFE <u>Ruth Tatum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT Address <u>Mrs. Elma Davis, Sturgeon, Missouri</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>Uremia due to urinary obstruction due to benign prostatic hypertrophy.</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <u>610X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>cerebral arteriosclerosis</u>					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	
21. I attended the deceased from <u>9/15/58</u> , to <u>12/26/59</u> and last saw ^{her} _{him} alive on <u>12/26/59</u> Death occurred at <u>7:30 a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Ruth Ward MD</u> (Degree or title)			22b. ADDRESS <u>Centralia, Missouri</u>		22c. DATE SIGNED <u>12-28-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>December 29, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Near Sturgeon, Missouri</u>
24. FUNERAL HOME ADDRESS <u>Dell's Meade Sturgeon, Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 29-1959</u>	26. REGISTRAR'S SIGNATURE <u>Maud M. Bride</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Securing the nearest contribution in the specific manner required by 193.140 MoRS 1949.
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.

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STATEMENT BY LICENSED EMBALMER

FEB 8 1960

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 *Bill J. Meador*

Licensed Embalmer No. *4876*

P. O. Address *Sturgeon, Missouri*

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.