

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-044620
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FILED VS JAN - 4 1960 174

Registration District No. _____ Primary Registration District No. 3035 Registrar's No. _____

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Lafayette				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MOSSOURI COUNTY Lafayette			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington		Length of stay in 1b 40 yrs		c. CITY OR TOWN Lexington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR Lexington Memorial Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 118 North 17th			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARRY Middle F. Last SMITH				4. DATE OF DEATH Month December Day 20 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1875	AGE (last birthday) 84	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teaching		11. BIRTHPLACE (City and state or country) Jacksonport, Wisc.		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME Joseph Smith		13b. MOTHER'S MAIDEN NAME Margaret Wilson		14. NAME OF HUSBAND OR WIFE Genevieve Russell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year, or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT May Russell		Address Lexington, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchial Pneumonia						INTERVAL BETWEEN ONSET AND DEATH 5 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) 1. Chronic myocarditis and nephritis						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 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 _____ 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 Dec 19 - '59 to Dec 20 - '59 and last saw him alive on Dec 20 - '59 Death occurred at 11:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Ben H Brascher, M.D.				22b. ADDRESS Lexington Mo		22c. DATE SIGNED 12/22/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/22/1959	23c. NAME OF CEMETERY OR CREMATORY Machpelah		23d. LOCATION (City, town, or county) Lexington, Mo		(State)	
24. FUNERAL DIRECTOR Fairfax Funeral Home			ADDRESS	25. DATE RECD. BY LOCAL REG. 12-23-59	26. REGISTRAR'S SIGNATURE Manana Eastman		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 14 1961

MAR 27 1961

MS
SEP 29 1961

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 Forest F. Stimpel

Licensed Embalmer No. 3270

P. O. Address Lexington

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.