

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000639

FILED VS JAN 20 1960

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 11

STATE FILE NUMBER

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>CASS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>CASS</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HARRISONVILLE</u>		Length of stay in 1b <u>4 yrs.</u>		c. CITY OR TOWN <u>HARRISONVILLE</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>403 N. Independence</u>				d. STREET ADDRESS (If outside, give location) <u>601 Sycamore</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>Smiley</u> Last				4. DATE OF DEATH Month <u>JAN</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>009 27-1883</u>	
9. AGE (last birthday) <u>77</u>		IF UNDER 1 YEAR Months		IF UNDER 24 HR Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Cass County, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				13a. FATHER'S NAME <u>Issac Newton Smiley</u>		13b. MOTHER'S MAIDEN NAME <u>Alice Woolery</u>	
14. NAME OF HUSBAND OR WIFE <u>NONE</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>Virgil Smiley 1245 Colorado K.C. Mo</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>coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 or 4 minutes</u>	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <u>coronary occlusion</u>			
20c. TIME OF INJURY Hour <u>1:00</u> Month, Day, Year <u>JAN 8-60</u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her/him live on _____ Death occurred at <u>1:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Dr. Robert Phillipson, Cass County Coroner</u>				22b. ADDRESS <u>302 S. Independence St. Mo.</u>		22c. DATE SIGNED <u>Jan 9, 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1-10-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Austin Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>ARCHIE, MISSOURI</u>	
24. FUNERAL DIRECTOR <u>ATKINSON Dickey</u>				ADDRESS <u>HARRISONVILLE, MO</u>		25. DATE RECD. BY LOCAL REG. <u>1-10-60</u>	
				26. REGISTRAR'S SIGNATURE <u>Mr. Roy Sebrae</u>			

**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 Robert Collinson

Licensed Embalmer No. 4902

P. O. Address Narragansett

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.