

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-000681

FILED VS JAN 18 1960

Registration District No. 64 Primary Registration District No. 5245 Registrar's No. 2

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Chariton</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Keytesville twp.</u> Length of stay in 1b <u>3 mo.</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chariton Co. Rest Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Chariton</u> c. CITY OR TOWN <u>Bynumville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) ----- Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Franklin</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/74</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>27</u> IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Chariton County</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Eke Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Johnson</u>		14. NAME OF HUSBAND OR WIFE <u>Linda Smith</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>C.K. Billeter, Salisbury, 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>Hypertrophy Heart</u> Hypertrophy <u>Heart Block</u> DUE TO (b) <u>Hypertrophy Heart</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
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 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.)			
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 <u>July 5th - 1959</u> to <u>Jan. 9th - 60</u> and last saw him alive on <u>Jan. 9th 80</u> Death occurred at <u>7:15 P.M. 7:15 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J.L. Feter, D.O.</u> (In green or title)			22b. ADDRESS <u>Brunswick MO</u>		22c. DATE SIGNED <u>Jan-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 12 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fitzgerald Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>2 mi. S.W. Bynumville, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>H. J. Galloway New Cambria Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-14-60</u>	26. REGISTRAR'S SIGNATURE <u>Dev Hawkins</u>		

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed H. J. Billiland

Licensed Embalmer No. 4019

P. O. Address New Cambria

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.