

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

**60-010395**

**FILED VS MAR 29 1966 096**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <b>Dallas</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dallas</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>S. Benton Twsp</b>		Length of stay in 1b <b>3 yrs.</b>	c. CITY OR TOWN <b>Elkland</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Elkland Rt. 2</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Rt. # 2</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lester Harry Smith</b>			4. DATE OF DEATH Month Day Year <b>March 22, 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 7, 1900</b>	9. AGE (last birthday) <b>60</b> IF UNDER 1 YEAR Months <b>2</b> Days <b>15</b> Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (City and state or country) <b>Leadmine, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>US</b>		
13a. FATHER'S NAME <b>Rueben Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Margaret Butts</b>		14. NAME OF HUSBAND OR WIFE <b>Nora Smith</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>500-01-2529</b>	17. INFORMANT <b>Nora Smith Rt. 2 Elkland, Missouri</b>			
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>Broncho-Pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Paralysis of Pharynx</b> DUE TO (c) <b>insertion of tube into stomach</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 type="checkbox"/> No <input type="checkbox"/> Unknown					INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <del>3</del>	
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 <b>1959</b> to <b>3-22-60</b> and last saw <del>him</del> <sup>her</sup> alive on <b>3-22-60</b> Death occurred at <b>11:00 AM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>C. O. Harmon M.D.</b>			22b. ADDRESS <b>Buff 210 Mo</b>		22c. DATE SIGNED <b>3-24-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>March 24, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Macedonia Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Dallas County Missouri</b>			
24. FUNERAL DIRECTOR <b>Montgomery Funeral Home Buffalo, Missouri</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3/27/60</b>	26. REGISTRAR'S SIGNATURE <b>Mrs Vera Petree</b>		

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 Reynolds Montgomery

Licensed Embalmer No. 3592

P. O. Address Buffalo, Miss

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.