

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014104

FILED VS. MAY 16 1960

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Primary Registration District No. 5037

Registrar's No. 119

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <b>Audrain</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Audrain</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saltriver</b>		Length of stay in 1b <b>18 months</b>	c. CITY OR TOWN <b>Thompson</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>Coldwell Nursing Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>R.F.D.#2</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Morris</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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. 30, 85</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Audrain Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>O.W. Smith</b>	13b. MOTHER'S MAIDEN NAME <b>Fannie Gantt</b>	14. NAME OF HUSBAND OR WIFE <b>Lilia Smith</b>
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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>486-309099</b>	17. INFORMANT <b>Mrs. Joseph Smith</b>	Address <b>Thompson, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>1 week.</b> <b>10 yrs.</b>
IMMEDIATE CAUSE (a)	<b>Cerebral Hemorrhage</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Hypertension</b>	
DUE TO (b)	<b>Benignity</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 type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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
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21. I attended the deceased from **1925** to **May 5** and last saw him alive on **May 5-1960**  
Death occurred at **5:20 p.m.** of the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>J. A. Barrell D.O.</b> (Degree or title)	22b. ADDRESS <b>Mexico Mo</b>	22c. DATE SIGNED <b>5-16/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 7, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood</b>	23d. LOCATION (City, town, or county) <b>Mexico, Mo.</b>	(State)
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24. FUNERAL DIRECTOR <b>Precht-Hueston</b>	ADDRESS <b>Mexico, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>May 7-1960</b>	26. REGISTRAR'S SIGNATURE <b>Blanche Neely</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAY 18 1980

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 Ralph P. Hines

Licensed Embalmer No. 468

P. O. Address Mexico

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.