

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-015096

FILED VS APR 25 1960

Registration District No. 142 Primary Registration District No. 6386 Registrar's No. 27

STATE FILE NUMBER

DED

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|--|--|---|--|---|---|--|---|---|------------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Howell</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Texas</u> | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francis</u> | | Length of stay in 1b <u>1 1/2</u> days | | c. CITY OR TOWN <u>Cabool</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>St. Francis Hospital</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 checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Agnes</u> Last <u>Smith</u> | | | | 4. DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>60</u> | | | | | | | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2-11-1890</u> | | 9. AGE (last birthday) <u>70</u> | | 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) <u>housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Lincoln County, Kan.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | | | |
| 13a. FATHER'S NAME <u>William Jasko</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth</u> | | | | 14. NAME OF HUSBAND OR WIFE <u>Fred 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>none</u> | | 17. INFORMANT Address <u>Fred Smith, Cabool, 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>Nephrosclerosis (probable)</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive and arteriosclerotic vascular disease.</u> | | | | | | | | | | | | | |
| 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 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>April 14 - 1960</u> to <u>April 15 1960</u> and last saw her/him alive on <u>April 15 1960</u> Death occurred at <u>10:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Name or title) <u>Amos L. Cotter M.D.</u> | | | | | | 22b. ADDRESS <u>Willow Springs Mo.</u> | | | 22c. DATE SIGNED <u>4/20/60</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 23b. DATE <u>4-19-60</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cabool Cemetery</u> | | | 23d. LOCATION (City, town, or county) <u>Cabool, Missouri</u> | | | (State) | | | |
| 24. FUNERAL DIRECTOR <u>James Gentry, Cabool, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>4-20-60</u> | | 26. REGISTRAR'S SIGNATURE <u>Lavera Mitchell</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 James L. Nealey

Licensed Embalmer No. 4718

P. O. Address Calooli

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.