

# MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-016207

FILED VS APR 25 1960

STATE FILE NUMBER

Registration District No. 226 Primary Registration District No. 4336 Registrar's No. 21

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONROE</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HOLLIDAY</u> Length of stay in lb <u>71 YRS</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WEST HOLLIDAY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MONROE</u> c. CITY OR TOWN <u>HOLLIDAY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>WEST HOLLIDAY</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>FANNIE</u> Middle <u>M.</u> Last <u>SMITH</u>			<b>4. DATE OF DEATH</b> Month <u>APRIL</u> Day <u>7</u> Year <u>1960</u>				
5. SEX <u>F</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>3/26/1889</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>10</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>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>MONROE CO. MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>THOMAS P. DAWSON</u>			13b. MOTHER'S MAIDEN NAME <u>CELIA E. DENNISON</u>		14. NAME OF HUSBAND OR WIFE <u>ROBERT L. 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 <u>HARDIN DAWSON</u> Address <u>P.O. D. PARIS, MO.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary accidents -</u> DUE TO (b) <u>coronary - arteriosclerosis</u> DUE TO (c) <u>chronic conditions of aye.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>NT</u>		
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>March 6</u> to <u>April 7th</u> and last saw her alive on <u>April - 7th - 6th</u> Death occurred at <u>6:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Helen J. Christman</u>				22b. ADDRESS <u>PARIS, MO</u>		22c. DATE SIGNED <u>4/7/1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APR. 10 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>HOLLIDAY, MO.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>E. H. AGNEW</u> <u>PARIS, MO.</u>			25. DATE RECD. BY LOCAL REG. <u>April 12 1960</u>		26. REGISTRAR'S SIGNATURE <u>Elsie Miller</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 E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, Md.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.