

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025694

FILED VS. JUL 19 1960

4

Primary Registration District No. 4014

Registrar's No. 195

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Atchison				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Atchison					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fairfax		Length of stay in 1b		c. CITY OR TOWN Rock Port.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Fairfax Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) none		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Laura Smith				4. DATE OF DEATH Month Day Year 7 13 1960					
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7-9-1908	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months 0 Days 4 Hours Min. 	IF UNDER 24 HR Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Atchison Co., Mo.		12. CITIZEN OF WHAT COUNTRY US		
13a. FATHER'S NAME D.C. White			13b. MOTHER'S MAIDEN NAME McClain			14. NAME OF HUSBAND OR WIFE Freddie Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Freddie Smith, Rock Port., Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO (b) primary in large Bowell DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 4 years.		
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"/> N- <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 checked="" 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 May 1956 to 7-13-60 and last saw her ^{her} alive on 7-13-60 Death occurred at 9 Am m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Wallace Carpenter MD				22b. ADDRESS Rock Port Mo				22c. DATE SIGNED 7-14-60	
22d. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE 7-15-1960	22c. NAME OF CEMETERY OR CREMATORY Hunter Cemetery.		22d. LOCATION (City, town, or county) Rock Port., Mo.			(State)	
24. FUNERAL DIRECTOR Bartholomew Mortuary, Rock Port.				ADDRESS		25. DATE RECD. BY LOCAL REG. July 14, 1960		26. REGISTRAR'S SIGNATURE Therone W. Scherler	

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 *Geoff Burchatacum*

Licensed Embalmer No. 3173

P. O. Address Rock Port, M

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.