

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-029459

FILED VS AUG 3 1960

Registration District No. 274 Primary Registration District No. 6272 Registrar's No. 21

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Worth County</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Fletcher Township</u>		Length of stay in 1b		c. CITY OR TOWN <u>Sheridan Missouri</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5-miles N-W-of Grant City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Avis</u> Middle <u>Smith</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1960</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>July 9, 1913</u>	9. AGE (last birthday) <u>46</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u>		IF UNDER 24 HR Hours <u>17</u> 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 <u>housewife</u>		11. BIRTHPLACE (City and state or country) <u>Athelston Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Benjamin E. Deardouff</u>		13b. MOTHER'S MAIDEN NAME <u>Maggie Busco</u>		14. NAME OF HUSBAND OR WIFE <u>Ellis 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> <u>none</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Ellis Smith Grant City Missouri</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>Uremia</u> DUE TO (b) <u>Nephritis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>3mos</u> <u>15yrs</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 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>1960</u> to <u>June 28, 60</u> and last saw her alive on <u>June 27</u> Death occurred at <u>6pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Frank B Matteson MD</u>		22b. ADDRESS <u>Grant City, Mo</u>		22c. DATE SIGNED <u>6/30/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>June-30-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Athelston Cemetery</u>		23d. LOCATION (City, town, or county) <u>Athelston Iowa</u>		(State)	
24. FUNERAL DIRECTOR <u>John Andrews</u>		ADDRESS <u>Grant City Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>7-27-1960</u>		26. REGISTRAR'S SIGNATURE <u>Leta Dawson</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

7-1-1900

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 John Andrews, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John Andrews

Licensed Embalmer No. 4211

P. O. Address Grant City

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.