

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033217

FILED V9 SEP 7 1960

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 2450

STATE FILE NUMBER

INDEXED

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ST LOUIS</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>CALIFORNIA</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>CLAYTON</b>                   |  | Length of stay in 1b<br><b>2 DAYS</b>   | c. CITY OR TOWN <b>FALLBROOK</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>COUNTY HOSPITAL</b> |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location) <b>805 N. STAGE COACH LA.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

|                                     |                      |                        |                    |                  |                |               |                |
|-------------------------------------|----------------------|------------------------|--------------------|------------------|----------------|---------------|----------------|
| 3. NAME OF DECEASED (Type or print) | First <b>Mervale</b> | Middle <b>DENSMORE</b> | Last <b>SMILEY</b> | 4. DATE OF DEATH | Month <b>8</b> | Day <b>14</b> | Year <b>60</b> |
|-------------------------------------|----------------------|------------------------|--------------------|------------------|----------------|---------------|----------------|

|                    |                               |   |                                   |                                  |                 |                |
|--------------------|-------------------------------|---|-----------------------------------|----------------------------------|-----------------|----------------|
| 5. SEX <b>MALE</b> | 6. COLOR OR RACE <b>WHITE</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>4-16-1891</b> | 9. AGE (last birthday) <b>69</b> | IF UNDER 1 YEAR | IF UNDER 24 HR |
|                    |                               |   |                                   | Months                           | Days            | Hours Min.     |

|  |   |  |   |
|--|---|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BANKER - RETIRED</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BANKING</b> | 11. BIRTHPLACE (City and state or country)<br><b>LE MARS, IOWA</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |
|--|---|--|---|

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME<br><b>Wm. D. SMILEY</b> | 13b. MOTHER'S MAIDEN NAME<br><b>CLARA SMILEY ?</b> | 14. NAME OF HUSBAND OR WIFE<br><b>JANE H. SMILEY</b> |
|--|--|--|

|  |   |  |                                     |
|--|---|--|-------------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>387-18-7738</b> | 17. INFORMANT<br><b>JANE H. SMILEY</b> | Address<br><b>FALLBROOK, CALIF.</b> |
|--|---|--|-------------------------------------|

|  |  |                                  |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a)  | <b>Massive Intraabdominal Hemorrhage</b>       | <b>11 hrs</b>                    |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.               | DUE TO (b) <b>Ruptured liver due to trauma</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.<br><input type="checkbox"/> Yes <input checked="" 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.) |
|--|---|--|

|                     |           |                  |
|---------------------|-----------|------------------|
| 20c. TIME OF INJURY | Hour      | Month, Day, Year |
|                     | a.m. p.m. |                  |

|   |  |                              |        |       |
|---|--|------------------------------|--------|-------|
| 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 **8-14-60** to **8-14-60** and last saw her/him alive on **8-14-60**  
 Death occurred at **7:25 P** on the date stated above, and to the best of my knowledge, from the causes stated.

|  |                                  |  |                  |
|--|----------------------------------|--|------------------|
| 22a. SIGNATURE<br><b>Robert J. Vorhaus</b> | (Degree or title)<br><b>M.D.</b> | 22b. ADDRESS<br><b>601 So. Brentwood Clayton Mo.</b> | 22c. DATE SIGNED |
|--|----------------------------------|--|------------------|

|   |                             |  |   |
|---|-----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b> | 23b. DATE<br><b>8-17-60</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LE MARS CITY CEM.</b> | 23d. LOCATION (City, town, or county) (State)<br><b>LE MARS, IOWA</b> |
|---|-----------------------------|--|---|

|  |                                 |  |  |
|--|---------------------------------|--|--|
| 24. FUNERAL DIRECTOR<br><b>C. R. Lupton &amp; Sons</b> | ADDRESS<br><b>St. Louis, Mo</b> | 25. DATE RECD. BY LOCAL REG.<br><b>8-17-60</b> | 26. REGISTRAR'S SIGNATURE<br><b>John C. Murphy Md.</b> |
|--|---------------------------------|--|--|

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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Charles H. Morris

Licensed Embalmer No. 4014

P. O. Address H. Lavin

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.