

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035887

FILED VS SEP 28 1960

Registration District No. 316 Primary Registration District No. - Registrar's No. 376

STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Cantwell</b>		Length of stay in lb <b>20 years</b>	c. CITY OR TOWN <b>Cantwell</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		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 <b>Zebeleon</b> Middle <b>Edward</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1892 - 67</b>	9. AGE (last birthday)	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) <b>Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (City and state or country) <b>Aspen, Colorado</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Edward F. Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Nellie Taylor</b>		14. NAME OF HUSBAND OR WIFE <b>Callie Smith</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>497 03 3034</b>		17. INFORMANT Address <b>Robert Smith, Cantwell, Missouri.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer - Stomach -</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 M</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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. <input type="checkbox"/> Yes <input type="checkbox"/> N- <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 _____ 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 <b>July 22/60</b> to <b>Sept 22/60</b> and last saw him alive on <b>Sept 21/60</b> Death occurred at <b>3:30A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>F. W. Zupan D.O.</b> (Degree or title)		22b. ADDRESS <b>Flat River, Mo.</b>		22c. DATE SIGNED <b>9/23/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/24/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Francois Mem. Pk</b>		23d. LOCATION (City, town, or county) (State) <b>St. Francois Co. Mo</b>

24. FUNERAL DIRECTOR <b>C.Z. Boyer &amp; Son, DeBlage, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>Sept. 23, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Ether Rudloff</b>
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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 B. T. Boyed

Licensed Embalmer No. 3660

P. O. Address Desloge, Miss

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.