

FEDERAL BUREAU OF INVESTIGATION VS NOV 2 1960
FRI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038901

STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 96

1. PLACE OF DEATH a. COUNTY <u>LAWRENCE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>SHELBY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>		Length of stay in 1b <u>27 days</u>	c. CITY OR TOWN <u>LEONARD</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. S. San.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RT. #3</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MUNRO</u> Middle <u>SMITH</u> Last <u>SMITH</u>			4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-12-91</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life or retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (City and state or country) <u>Shelby County</u>	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME <u>ALONZO SMITH</u>	13b. MOTHER'S MAIDEN NAME <u>MARY CRAWFORD</u>	14. NAME OF HUSBAND OR WIFE <u>NEOMA SMITH</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>347-10-9169</u>	17. INFORMANT <u>MOSP. RECORD</u> Address
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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>COR PULMONALIE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-12 Mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>PULMONARY T.B.C.</u>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>RECTAL ABCESS</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> 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
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21. I attended the deceased from 10-3-60 to 10-29-60 and last saw him alive on 10-28-60
 Death occurred at 5:30 AM 10-29-60 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Describe or title) <u>Dr. Hobbs, M.D.</u>	22b. ADDRESS <u>Mt. Vernon Mo</u>	22c. DATE SIGNED <u>10-29-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-29-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Leonard Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Leonard Mo.</u>
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24. FUNERAL DIRECTOR <u>Greening Funeral Home Shelbyville Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>10-29-60</u>	26. REGISTRAR'S SIGNATURE <u>H H Fossitt</u>
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(License of Embalmer's Statement on Reverse Side)

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 me Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H. D. Forett

Licensed Embalmer No. 2201
P. O. Address W. H. memo

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