RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-60-045857
STATE FILE NUMBER

FILED VS JAN 3 1961

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 185

DED

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN West Plains — Length of stay in 1b 30 years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Howell
c. CITY OR TOWN West Plains — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First William Middle Homer Last Smith

4. DATE OF DEATH Month December Day 19 Year 1960

5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 10-25-86
9. AGE (last birthday) 74 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and state or country) Sycamore, Missouri
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME George Smith
13b. MOTHER'S MAIDEN NAME Margaret Martin
14. NAME OF HUSBAND OR WIFE Ora Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Ora Smith, West Plains, Missouri

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH 12 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Thrombosis — 2 days
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) (1) Cerebral Arteriosclerosis (2) Previous Thrombosis

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1952, to 12-19-60 and last saw ~~her~~ ~~him~~ alive on 12-19-60
Death occurred at 3:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Jack N. Wiles M.D.
22b. ADDRESS West Plains Mo
22c. DATE SIGNED 12-22-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 12-21-1960
23c. NAME OF CEMETERY OR CREMATORY Howell Mem. Cemetery
23d. LOCATION (City, town, or county) (State) West Plains, Missouri

24. FUNERAL DIRECTOR Leland Carter — ADDRESS West Plains Mo
25. DATE RECD. BY LOCAL REG. 12-28-60
26. REGISTRAR'S SIGNATURE Beatrice Cook

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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