

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004864

STATE FILE NUMBER

AMENDED

Registration District No. 11 Primary Registration District No. 3012 Registrar's No. 19

FILED VS FEB 27 1961

1. PLACE OF DEATH a. COUNTY <b>Clay</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Excelsior Springs</b>	Length of stay in lb <b>15 yrs</b>	c. CITY OR TOWN <b>Excelsior Springs</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Spa-View Health Haven</b>		d. STREET ADDRESS (If outside, give location) <b>507 South Street</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JACKSON</b> Middle <b>*****</b> Last <b>SMITH</b>			4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-24-82</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	11. BIRTHPLACE (City and state or country) <b>Burns, Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>W. Dan Smith</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Margaret Cole</b>	14. NAME OF HUSBAND OR WIFE <b>Zoah May Bailey</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>	17. INFORMANT <b>Chas. J. Smith</b> Address <b>Rural Route #1 Excelsior Sp'gs, Mo.</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Pulmonary Infection</b>		<b>30 min</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Post operative Rt Leg Amputation</b>	<b>2 weeks</b>
	DUE TO (c) <b>Generalized Arteriosclerosis.</b>	<b>Years.</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>Diabetes. Coronary Insufficiency.</b>	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.)
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 **Sept. 1960** to **Feb 18, 1961** and last saw him alive on **Feb 1, 1961**  
Death occurred at **10:25 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>James R. Allan, M.D.</b>	22b. ADDRESS <b>Excelsior Springs, Mo</b>	22c. DATE SIGNED <b>2-21-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-20-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Excelsior Springs, Mo.</b>
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24. FUNERAL DIRECTOR <b>Hope Funeral Home</b>	ADDRESS <b>216 Spring St.</b>	25. DATE RECD. BY LOCAL REG. <b>2-19-61</b>	26. REGISTRAR'S SIGNATURE <b>Caroline Hutchings</b>
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Excelsior Springs, Mo. (Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed E. L. Gibson

Licensed Embalmer No. 4137

P. O. Address P.O. Box 808  
Excelsior Springs, Mo.

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.