

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-038163

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 210 Primary Registration District No. 3058 Registrar's No. 277

AMENDED

FILED NOV 15 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Saint Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Indiana</u> b. COUNTY <u>Howard</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only). <u>Saint Charles</u>		Length of stay in 1b <u>20 min.</u>		c. CITY OR TOWN <u>Kokomo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>417 W. Walnut</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Lucille</u> Last <u>Smissen</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1961</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1903</u>		9. AGE (last birthday) <u>58</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>7</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, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own</u>		11. BIRTHPLACE (City and state or country) <u>Kokomo, Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Winfield Lines</u>				13b. MOTHER'S MAIDEN NAME <u>unknown</u>				14. NAME OF HUSBAND OR WIFE <u>Wm. P. Smissen</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Wm. P. Smissen, Kokomo, Ind.</u>							
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>Hemo-pneumo - thorax</u>										INTERVAL BETWEEN ONSET AND DEATH <u>20 mi</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Broken ribs</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)								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					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <u>Car went off onto shoulder of Inter-</u>									
20c. TIME OF INJURY <u>11:45 <del>xxx</del></u>		Hour <u>11</u> a.m. <u>xxx</u> Month, Day, Year <u>11/8/61</u>		state # <u>70</u> , tipped on right side, skidded 492! Car returned upright - victim thrown out of car									
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.) <u>Interstate # 70</u>		20f. CITY, TOWN, OR LOCATION <u>Warren Co.</u>		COUNTY <u>Missouri</u>		STATE					
21. I attended the deceased from <u>held view</u> to <u>Nov. 8, 1961</u> and last saw her/him alive on _____ Death occurred at <u>12:50 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Frank R. Amaloug</i> (Degree or title)						22b. ADDRESS <u>MO. 12 Cunningham Ct. St. Chas.</u>			22c. DATE SIGNED <u>11/8/61</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			23b. DATE <u>Nov. 9, 1961</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Crown Point Cemetery</u>			23d. LOCATION (City, town, or county) <u>Kokomo, Indiana</u>				
24. FUNERAL DIRECTOR <u>Jacobs Funeral Home, Kokomo, Ind.</u>					25. DATE RECD. BY LOCAL REG. <u>Nov 8, 1961</u>		26. REGISTRAR'S SIGNATURE <i>Marcelle Wilson</i>						

JAN 4 1963

JAN 4 1963

MAR 30 1962

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 Grand R. Amalany

Licensed Embalmer No. 4833

P. O. Address St Charles

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.