

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-039869

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 6178 Registrar's No. 90

AMENDED

1. PLACE OF DEATH a. COUNTY <u>Sullivan County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Browning Rural</u>		c. CITY OR TOWN <u>Browning</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fred Smith Home</u>		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			
First <u>Ada</u>		Middle <u>Lee</u>	
Last <u>Smith</u>		4. DATE OF DEATH	
Month <u>Oct</u>		Day <u>18</u>	
Year <u>61</u>		Year <u>61</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/82</u>
9. AGE (last birthday) <u>79</u>		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) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James Hoskins</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Dodson</u>	
14. NAME OF HUSBAND OR WIFE _____		_____	
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. _____	
17. INFORMANT <u>Fred Smith</u>		Address <u>Browning</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>Cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
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"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ Month, Day, Year _____	
a.m. _____ p.m. _____		_____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
NOT WHILE AT WORK <input type="checkbox"/>		_____	
20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____	
_____		_____	
21. I attended the deceased from <u>9-30-1961</u> <u>7</u> <u>AM</u> to <u>October 18, 1961</u> and last saw her <u>him</u> alive on <u>Oct 13, 1961</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J.P. Melton</u>		(Degree or title) <u>M.D.</u>	
22b. ADDRESS <u>Browning Mo</u>		22c. DATE SIGNED <u>10-18-1961</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/20/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Knifong</u>		23d. LOCATION (City, town, or county) (State) <u>Browning Mo.</u>	
24. FUNERAL DIRECTOR <u>Wade Funeral Home</u>		ADDRESS <u>Browning</u>	
25. DATE RECD. BY LOCAL REG. <u>10-23-61</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. M.W. Beckett</u>	

DATE AMENDED

INSTEAD OF

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ronald T. Sad

Licensed Embalmer No. 4172

P. O. Address Brown

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.