

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-040479

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 7.5 Primary Registration District No. 3013 Registrar's No. 115

FILED NOV 27 1961

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Clinton</b>                                     |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>DeKalb</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Cameron</b>       | Length of stay in 1b<br><b>33 yr, s</b> | c. CITY OR TOWN<br><b>Cameron</b>  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                              |
| c. FULL NAME OF (If NOT in hospital, give location)<br><b>Cameron Comm. Hosp.</b> |   | d. STREET ADDRESS<br><b>N Harris</b>   | (If outside, give location) Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lillie</b> Middle <b>M</b> Last <b>Smith</b> | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>13</b> Year <b>1961</b> |
|--|--|

|                    |                                  |   |  |                                     |  |  |
|--------------------|----------------------------------|---|--|-------------------------------------|--|--|
| 5. SEX<br><b>F</b> | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 9 1887</b> | 9. AGE (last birthday)<br><b>74</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
|--------------------|----------------------------------|---|--|-------------------------------------|--|--|

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|---|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>House Keeper</b> | 11. BIRTHPLACE (City and state or country)<br><b>Osborn Mo</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>U. S. A.</b> |
|---|--|--|--|

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|---|--|--|
| 13a. FATHER'S NAME<br><b>Joseph McQuate</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Elizabeth Holtzapple</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Carl Smith</b> |
|---|--|--|

|   |                         |   |         |
|---|-------------------------|---|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO. | 17. INFORMANT<br><b>Owen McQuate, Osborn, Mo.</b> | Address |
|---|-------------------------|---|---------|

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Diabetes Mellitus</b><br>DUE TO (b) <b>Arteriosclerotic Hypertension</b><br>DUE TO (c) <b>Heart Disease &amp; Accompanying 5 yrs</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 yrs</b>  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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|--|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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<br><b>Osborn</b> | COUNTY<br><b>Mo.</b> | STATE |
|--|--|---|----------------------|-------|

21. I attended the deceased from **April 5 - 1947**, to **Nov 12, 1961** and last saw her alive on **Nov 12, 1961**  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                                    |                                     |
|---|------------------------------------|-------------------------------------|
| 22a. SIGNATURE<br><i>J. Leece</i> (Degree or title) <b>MD</b> | 22b. ADDRESS<br><b>Cameron, Mo</b> | 22c. DATE SIGNED<br><b>11-15-61</b> |
|---|------------------------------------|-------------------------------------|

|  |                                   |  |  |                          |
|--|-----------------------------------|--|--|--------------------------|
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) | 23b. DATE<br><b>Nov. 16, 1961</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen</b> | 23d. LOCATION (City, town, or county)<br><b>Osborn</b> | 23e. STATE<br><b>Mo.</b> |
|--|-----------------------------------|--|--|--------------------------|

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|---|---------|--|--|
| 24. FUNERAL DIRECTOR<br><b>Poland Funeral Home, Cameron, Mo</b> | ADDRESS | 25. DATE RECD. BY LOCAL REG.<br><b>Nov 19 1961</b> | 26. REGISTRAR'S SIGNATURE<br><i>Francis Crawford</i> |
|---|---------|--|--|

DATE AMENDED

INSTEAD OF DOCUMENT

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

*Robert J. Poland*

Licensed Embalmer No. 4777

P. O. Address 222 West 3<sup>rd</sup> St  
Cameron New

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.