

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045709

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 261 Primary Registration District No. 3048 Registrar's No. 248 STATE FILE NUMBER

AMENDED **FILED JAN 2 1962**

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Nodaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Nodaway</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Maryville</u>		Length of stay in 1b <u>30 days</u>	c. CITY OR TOWN <u>Maryville</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 Francis Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1012 E 5th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lois</u> Middle <u>Myrtle</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</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>1-9-1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Nursing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	11. BIRTHPLACE (City and state or country) <u>Hickering, Mo.</u>
13a. FATHER'S NAME <u>Wm. Reed McRee</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jones</u>	14. NAME OF HUSBAND OR WIFE <u>Ben F. Smith</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>		17. INFORMANT <u>Mrs. Helend Ditto, St. Joseph Mo</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>Acute Pulmonary Embolus</u> DUE TO (b) <u>Multiple Fractures - Contusions</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>18 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Ch. asthma</u>			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>Automobile - Multiple Fractures Contusions</u>	
20c. TIME OF INJURY Hour <u>4</u> a.m. p.m. Month, Day, Year <u>11/29/61</u>	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 <u>11/29/61</u> to <u>12/16/61</u> and last saw her/him alive on <u>12/16/61</u> Death occurred at <u>11:59 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>[Signature]</u>		22b. ADDRESS <u>Maryville Mo</u>	22c. DATE SIGNED <u>12/20/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-19-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Miriam Cemetery</u>	23d. LOCATION (City, town, or county) <u>Maryville, Mo.</u>
24. FUNERAL DIRECTOR <u>Atchison, Maryville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-26-61</u>	26. REGISTRAR'S SIGNATURE <u>Beas Bolt</u>

VS JAN 31 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 *E M Atkinson*

Licensed Embalmer No. 2279

P. O. Address *Marysville*

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.