

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001067

STATE FILE NUMBER

Registration District No. 119 Primary Registration District No. 5443 Registrar's No. 5

AMENDED

FILED JAN 17 1962

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

| | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>GASCONADE</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>FRANKLIN</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HERMAN MO</u> | | Length of stay in 1b <u>18 months</u> | c. CITY OR TOWN <u>GERALD. MO</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>FRENEVALLY, N.H.</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>RR 1</u> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN W SMITH</u> | | | 4. DATE OF DEATH Month Day Year <u>1-7-1962</u> |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</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>7-4-1868</u> |
| 9. AGE (last birthday) <u>93</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>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | 11. BIRTHPLACE (City and state or country) <u>UMA-ARIZONA</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>Unknown</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Deceased</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO NONE</u> | | 16. SOCIAL SECURITY NO. <u>[Redacted]</u> | |
| 17. INFORMANT <u>M. J. Smith</u> | | Address <u>Baselwood Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</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) <u>ARTERIOSCLEROTIC HEART DISEASE</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |
| 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 Month, Day, Year a.m. p.m. | | | |
| 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>DEC 1961</u> to <u>1-7-62</u> and last saw her alive on <u>1-7-62</u> Death occurred at <u>11:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>George M. Workman M.D.</u> | | 22b. ADDRESS <u>HERMANN</u> | 22c. DATE SIGNED <u>1-9-62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | 23b. DATE <u>1-10-1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St Paul</u> | 23d. LOCATION (City, town, or county) (State) <u>Baselwood RR2. MO</u> |
| 24. FUNERAL DIRECTOR <u>E. J. Meyer</u> | | ADDRESS <u>Baselwood Mo</u> | 25. DATE RECD. BY LOCAL REG. <u>1-9-62</u> |
| 26. REGISTRAR'S SIGNATURE <u>Delma Uffelman</u> | | | |

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 Stanley E. Meyer

Licensed Embalmer No. 4639

P. O. Address Union 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.