

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-006383

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 41

FILED MAR 13 1962

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		c. CITY OR TOWN <u>West Plains</u>	
Length of stay in lb yrs. _____		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>410 W. Olden</u>		d. STREET ADDRESS (If outside, give location) <u>410 W. Olden</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Maude May Smith</u>			4. DATE OF DEATH <u>Feb 21, 1962</u>		
First	Middle	Last	Month	Day	Year

5. SEX <u>Female</u>	6. COLOR OR RACE <u>wht.</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>2-26-1887</u>	9. AGE (last birthday) <u>74 yrs.</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours
					Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Widow</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>West Plains, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Tom Parker</u>	13b. MOTHER'S MAIDEN NAME <u>Clara Sinclair</u>	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Earp Parker, West Plains, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>		<u>48 hrs</u>
DUE TO (b) <u>Pulmonary edema</u>		<u>4 days</u>
DUE TO (c) <u>Arteriosclerotic heart disease</u>		<u>12 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>(1) Intestinal hemorrhage (2) Anasarca</u>		PART III. If deceased was female was there a pregnancy in last 90 days.
		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <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.) _____
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20c. TIME OF INJURY 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 _____ COUNTY _____ STATE _____
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21. I attended the deceased from 10-3-1960 to 2-20-62 and last saw her alive on 2-20-62
 Death occurred at 8:00 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Murray T. Pritchard, M.D.</u>	22b. ADDRESS <u>West Plains, Mo.</u>	22c. DATE SIGNED <u>2-28-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>2-25-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>West Plains, Mo.</u>
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24. FUNERAL DIRECTOR <u>Robertson's, West Plains, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-6-62</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 SHOULD READ
 ITEM NO.

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

D. H. Robertson

Licensed Embalmer No. 3432

P. O. Address West Plains, 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.