

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-014765

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 68

FILED APR 16 1962	
1. PLACE OF DEATH a. COUNTY <u>Dunklin</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Dunklin Co. Memorial</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dunklin</u> c. CITY OR TOWN <u>Clarkton</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>No street numbers</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E.</u> Last <u>Smith</u>	
4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/6/1893</u>
9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>5</u> Days _____
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>Farming</u>
11. BIRTHPLACE (City and state or country) <u>Jackson, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Jim Smith</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret</u>
14. NAME OF HUSBAND OR WIFE <u>Virgie Ballard 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>	
16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Virgie Smith, Clarkton, Mo.</u> Address _____	
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>Coronary Thrombosis</u> DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u> PART III. If deceased was female was there a pregnancy in last 90 days. Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
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"/> 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>4-4-62</u> to <u>4-6-62</u> and last saw her alive on <u>4-6-1962</u> Death occurred at <u>approximately 9:30a</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Print name and title) <u>George L. Summers M.D.</u> 22b. ADDRESS <u>Kennett Mo</u> 22c. DATE SIGNED <u>4/16/62</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/8/1962</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Ridge</u>	23d. LOCATION (City, town, or county) <u>Kennett Missouri</u>
24. FUNERAL DIRECTOR <u>McDaniel Funeral Ser. Kennett, Mo.</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>4-12-1962</u> 26. REGISTRAR'S SIGNATURE <u>Earl J. ...</u>

VS 300 Rev. 4/59
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 *James T. Roberts*

Licensed Embalmer No. 4886

P. O. Address Kennerly, 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.