

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-015756

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 160 Primary Registration District No. 559v Registrar's No. 57

FILED APR 17 1962

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY JEFFERSON

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN RURAL JOACHIM Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION MT. VIEW N.H. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY WAYNE

c. CITY OR TOWN MARQUAND Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) RR Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
FRANCES G. SMIT SMIT

4. DATE OF DEATH Month Day Year
4-5-62

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. Married Never Married
Widowed Divorced 8. DATE OF BIRTH 10-18-1897 9. AGE (last birthday) 64

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) HOUSEMAID & COOK 10b. KIND OF BUSINESS OR INDUSTRY PRIVATE HOME 11. BIRTHPLACE (City and state or country) CZECHOSLOVAKIA 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME JOSEPH SKODA 13b. MOTHER'S MAIDEN NAME UNKNOWN 14. NAME OF HUSBAND OR WIFE VENZEL SMIT

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 Address
VENZEL SMIT MARQUAND, MO.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of colon INTERVAL BETWEEN ONSET AND DEATH

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) Multiple metastases, peritoneum

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 2/16/62 to 4/1/62 and last saw her him alive on 4/1/62
Death occurred at 6:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) 22b. ADDRESS [Address] 22c. DATE SIGNED 4/9/62

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 4-9-62 23c. NAME OF CEMETERY OR CREMATORY ROSELAWN MEMORIAL 23d. LOCATION (City, town, or county) CRYSTAL CITY, MO.

24. FUNERAL DIRECTOR ADDRESS GENTRY R. POLITTE CRYSTAL CITY, MO. 25. DATE RECD. BY LOCAL REG. 4-9-62 26. REGISTRAR'S SIGNATURE [Signature]

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

APR 24 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 Geuleny R. Polittle

Licensed Embalmer No. 3481

P. O. Address Crystal City, 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.