

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-016369

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 290 Primary Registration District No. \_\_\_\_\_ Registrar's No. 48

FILED APR 25 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Pulaski</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pulaski</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Fort Leonard Wood</b>		Length of stay in 1b <b>1 week</b>	c. CITY OR TOWN <b>Fort Leonard Wood</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>US Army Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>34 Humphreys</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>LEONIE</b> Middle <b>R.</b> Last <b>SMITH</b>			4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1962</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>20Aug1902</b>
9. AGE (last birthday) <b>59</b>		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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>New Orleans, La.</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Unknown - Deceased</b>	
13b. MOTHER'S MAIDEN NAME <b>Frances Rezza (Deceased)</b>		14. NAME OF HUSBAND OR WIFE <b>Andrew J. Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Vernard J. Smith</b> Address: <b>34 Humphreys Ft Leonard Wood, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of Breast</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) 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			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
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 _____ 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 _____
21. I attended the deceased from <b>8 April 1962</b> to <b>15 April 1962</b> and last saw her <del>her</del> alive on <b>15 April 1962</b> . Death occurred at <b>12:45 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>George F. Scofield</i> <b>GEORGE F. SCOFIELD, Captain, MC</b>		22b. ADDRESS <b>US Army Hospital Fort Leonard Wood, Missouri</b>	22c. DATE SIGNED <b>4-16-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4-18-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Waynesville MO.</b>
24. FUNERAL DIRECTOR <i>Moss-Williams</i> <b>Moss-Williams</b>		25. DATE RECD. BY LOCAL REG. <b>4-17-62</b>	26. REGISTRAR'S SIGNATURE <i>Gaula Mae Anderson</i> <b>Gaula Mae Anderson</b>

APR 26 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 Clarence Pross

Licensed Embalmer No. 4896

P. O. Address Waynesville, 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.