

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-019438

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 171 Primary Registration District No. 4267 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY Lafayette		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Lafayette	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Odessa		Length of stay in 1b 25 yrs.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION At Home 518 S. Third		d. STREET ADDRESS (If outside, give location) 518 S. Third	
3. NAME OF DECEASED (Type or print) First Sallie Middle Belle Last Smith		4. DATE OF DEATH Month May Day 8 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/13/1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Lynchburg, Virginia
13a. FATHER'S NAME Joel Smith		14. NAME OF HUSBAND OR WIFE Harvey Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Marshall D. Smith, Odessa, 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) Inanation & Dehydration DUE TO (b) Semility DUE TO (c) F V Fluor PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 10 days 6-8 hrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.		20f. CITY, TOWN, OR LOCATION Odessa, Missouri	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from may years to death and last saw her/him alive on 8-9-62 Death occurred at 1:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>W. Martin</i>		22b. ADDRESS Odessa, Missouri	
22c. DATE SIGNED 5-9-62		23c. LOCATION (City, town, or county) (State) wt. Washington Cemetery Kansas City, Jackson, MO.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/10/1962	
24. FUNERAL DIRECTOR Ralph O. Jones, Odessa, Missouri		25. DATE RECD. BY LOCAL REG. 5-10-1962	
26. REGISTRAR'S SIGNATURE <i>Emma Davidson</i>			

VS 300
Rev. 4/59

DATE AMENDED
2.540
2.540
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4 1
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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

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

Ralph Jones

Licensed Embalmer No.

4604

P. O. Address

Odessa, 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.