

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025604

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1898

FILED JUL 2 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Le May, Missouri		Length of stay in 1b 5 mos	c. CITY OR TOWN LeMay, Missouri
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Etta Torrence Nursing Home		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 943 Urskin St.
3. NAME OF DECEASED (Type or print) First Annie Middle Smith Last		4. DATE OF DEATH Month 6 Day 26 Year 62	
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 2-1-1885
9. AGE (last birthday) 77		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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Galatin Co. Ill.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME A. B. Martin	
13b. MOTHER'S MAIDEN NAME Nancy Ann Flynn		14. NAME OF HUSBAND OR WIFE Joseph T. Smith Dec.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Ethel Clayton
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 1 year	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Myocarditis		DUE TO (c) Diabetes Mellitus & Atherosclerosis	
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	
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 _____ 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 <u>3-15-62</u> to <u>6-26-62</u> and last saw her/him alive on <u>6-26-62</u> Death occurred at <u>2:45 p.m.</u> <u>6-26-62</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John C. Crawford D.O.</i>		22b. ADDRESS <u>9612 S. Broadway</u>	22c. DATE SIGNED <u>6-26-62</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>6-29-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sikeston, Scott, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Nunnelee Funeral Home Sikeston, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-26-62</u>	26. REGISTRAR'S SIGNATURE <i>John C. Crawford M.D.</i>

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 H. Creamer

Licensed Embalmer No. 5168

P. O. Address Millstadt, Ill.

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.