

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-028139

STATE FILE NUMBER

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 142

DO NOT WRITE ON THIS STUB

AMENDED

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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

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

<p>FILED AUG 2 1962</p>		<p>1. PLACE OF DEATH</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p>	
<p>a. COUNTY <u>PHELPS</u></p>		<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ROLLA</u></p>		<p>a. STATE <u>MO.</u> b. COUNTY <u>FRANKLIN</u></p>	
<p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McFARLAND NURSING Home</u></p>		<p>Length of stay in 1b <u>3 mos.</u></p>		<p>c. CITY OR TOWN <u>SULLIVAN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN P. SMITH</u></p>		<p>4. DATE OF DEATH Month Day Year <u>JULY 12 1962</u></p>		<p>d. STREET ADDRESS (If outside, give location) <u>706 SARAH</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	
<p>5. SEX <u>MALE</u></p>		<p>6. COLOR OR RACE <u>WHITE</u></p>		<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH <u>JULY 4, 1890</u></p>		<p>9. AGE (last birthday) <u>82</u></p>		<p>IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u></p>		<p>11. BIRTHPLACE (City and state or country) <u>JAPAN, MO.</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>		<p>13a. FATHER'S NAME <u>WILLIAM JOSEPH SMITH</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>CLERINDA ENLOE</u></p>	
<p>14. NAME OF HUSBAND OR WIFE <u>ROSIE J. COOPER</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. <u>NONE</u></p>	
<p>17. INFORMANT <u>JESSE SMITH, GERALD, MO.</u></p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u></p>	
<p>PART I. DEATH WAS CAUSED BY:</p>		<p>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u></p>		<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>	
<p>DUE TO (b)</p>		<p>DUE TO (c)</p>		<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Had previous CVA.</u></p>	
<p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>		<p>20c. TIME OF INJURY Hour Month, Day, Year</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION</p>		<p>COUNTY STATE</p>	
<p>21. I attended the deceased from <u>May 1962</u> to <u>July 12, 1962</u> and last saw <u>her</u> alive on <u>July 11, 1962</u></p>		<p>Death occurred at _____ m on the date stated above, and to the best of my knowledge from the causes stated.</p>		<p>22a. SIGNATURE (Degree or title) <u>[Signature]</u></p>	
<p>22b. ADDRESS <u>Rolla MO</u></p>		<p>22c. DATE SIGNED <u>7/16/62</u></p>		<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>	
<p>23b. DATE <u>JULY 15, 1962</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>SCHMIDT CEM.</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>SULLIVAN R.P.I., MO.</u></p>	
<p>24. FUNERAL DIRECTOR <u>H.M. EATON, SULLIVAN, MO</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>July 23, 1962</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Madame L. Stoll</u></p>	

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

Harrison B. Eaton

Licensed Embalmer No. 4192

P. O. Address Sullivan, 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.