

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043686
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 221

FILED DEC 6 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Phelps</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Phelps</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u> | | Length of stay in lb <u>60 yrs.</u> | c. CITY OR TOWN <u>Rolla</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Phelps County Memorial Hosp</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>607 East 5th. st.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>MERCY</u> Middle <u>ETHEL</u> Last <u>SMITH</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1962</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/27/1879</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | 9. AGE (last birthday) <u>83</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____ |
| 11a. BIRTHPLACE (City and state or country) <u>Hicksville, Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>James E. Coulter</u> | | 13b. MOTHER'S MAIDEN NAME <u>Viola F. Johnson</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Charles Bland Smith (dec.)</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u> | |
| 16. SOCIAL SECURITY NO. <u>Unknown</u> | | 17. INFORMANT Address <u>Hallie Smith 607 E 5th. st., Rolla, Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral acute bronchopneumonia</u> DUE TO (b) <u>Cardiac decompensation</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>14 da.</u> <u>3-4 da.</u> <u>10+ yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>senile dementia</u> | | | 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>July 1952</u> , to <u>Nov. 28 1962</u> and last saw her/him alive on <u>Nov. 28, 1962</u> Death occurred at <u>2:20 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Barbara E. Russell, M.D.</u> | | 22b. ADDRESS <u>115 + Buhrig Rolla Mo</u> | |
| 22c. DATE SIGNED <u>11/29/62</u> | | 23. NAME OF CEMETERY OR CREMATORY <u>Rolla Cemetery</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-1-1962</u> | 23d. LOCATION (City, town, or county) <u>Rolla, Mo.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Carl J. Glenn West 10th. st., Rolla, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Nov. 29, 1962</u> | 26. REGISTRAR'S SIGNATURE <u>Nadene L. Steel</u> |

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 Carl J. Glenn

Licensed Embalmer No. 4707

P. O. Address Rolla, 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.