

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## =62-046295

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 93 Primary Registration District No. 3015 Registrar's No. 2

**FILED JAN 9 1963**

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Caldwell</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Cameron</b>		c. CITY OR TOWN <b>Hamilton</b>	
Length of stay in 1b <b>2 Days</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>Cameron Community Hosp</b>		d. STREET ADDRESS (If outside, give location) <b>Hamilton</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Henry</b> Last <b>Smith</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>26</b> Year <b>1962</b>	
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5. SEX <b>Male</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>12-6-1883</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Farmer</b>	11. BIRTHPLACE (City and state or country) <b>Hamilton, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S. A.</b>
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13a. FATHER'S NAME <b>John Smith</b>	13b. MOTHER'S MAIDEN NAME <b>Helenn McClellan</b>	14. NAME OF HUSBAND OR WIFE <b>Edith Smith</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	17. INFORMANT Address <b>Edith Smith Hamilton, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>		<b>40 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b>		<b>Indef</b>
DUE TO (c) <b>Senility</b>		<b>Indef</b>

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 type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> s.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	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
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21. I attended the deceased from 12/28/62 to 12/29/62 and last saw him alive on 12/29/62  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Edith Smith</i>	22b. ADDRESS <i>Hamilton, Mo.</i>	22c. DATE SIGNED <i>12/29/62</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-3-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Highland Cemetery</b>	23d. LOCATION (City, town, or county) <b>Hamilton Mo.</b>
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24. FUNERAL DIRECTOR <b>Morris Bram</b>	ADDRESS <b>Hamilton, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>1-3-63</b>	26. REGISTRAR'S SIGNATURE <i>Francis D Crawford</i>
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DATE AMENDED  
1/29/63  
12/26/62  
12/29/62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

JAN 11 1963

JAN 16 1963

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 Billie C. Gonder

Licensed Embalmer No. 4980

P. O. Address Hamilton, 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.