

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

#62-046390

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 99

Primary Registration District No. \_\_\_\_\_

Registrar's No. 1

FILED JAN 15 1963

VS 300  
Rev. 4/59

10320  
20320

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4 0  
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94222

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12 90-2  
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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

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>DeKalb</u>		a. STATE <u>Mo</u> b. COUNTY <u>DeKalb</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clarksdale</u>		c. CITY OR TOWN <u>Clarksdale</u>	
Length of stay in lb <u>Life</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home 3 Mi, West</u>		d. STREET ADDRESS (If outside, give location) <u>3 Mi, West of town</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH
First <u>Bird</u> Middle _____      Last <u>Smith</u>			Month <u>12</u> Day <u>30</u> Year <u>62</u>
5. SEX <u>Male</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>7-2-1875</u>
9. AGE (last birthday) <u>87</u>		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) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Kansas</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Brook Smith</u>	
13b. MOTHER'S MAIDEN NAME <u>Annie Stewart</u>		14. NAME OF HUSBAND OR WIFE <u>none</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>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Joe Smith</u>		Address <u>Clarksdale Mo</u>	
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 <u>6 hrs</u>
IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u>			
DUE TO (b) <u>Seminality</u>			
DUE TO (c) _____			
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
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 _____ Month, Day, Year _____ a.m. _____ p.m.			
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>1961</u> to <u>Dec 30, 1962</u> and last saw him alive on <u>Dec 29, 1962</u>			
Death occurred at <u>3:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. Dwyer</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>Camecon, Mo</u>	22c. DATE SIGNED <u>1-7-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-2-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St Joseph, Mo</u>
24. GENERAL DIRECTOR <u>John Brown</u> ADDRESS <u>Maysville, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Jan-10-1963</u>	26. REGISTRAR'S SIGNATURE <u>Herb C. Davidson</u>

JAN 1 1998

**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 John Brown

Licensed Embalmer No. 3933  
P. O. Address Waynesville 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.