

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-010762

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 161

FILED MAR 22 1963

VS 300
Rev. 4/59

DATE AMENDED

9-20-63
9-20-63

6169

29120

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94200

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122-0

131-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

8-1-1907
55

ITEM NO. SHOULD READ

8 8-1-1891
9 71

BY AFFIDAVIT OF Outstanding Pulmonary Embolism DOCUMENT Cape Girardeau, Mo. MEDICAL CERTIFICATION

Keep Records from Mt. Vernon, Mo.

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Cape Girardeau | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois COUNTY Alexander | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Cape Girardeau | | Length of stay in 1b 10 hrs. | c. CITY OR TOWN Unity Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Francis Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS None (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Gertie First Smith Middle --- Last Smith | | | 4. DATE OF DEATH Month March Day 10 Year 1963 |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8-1-1907 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY House Work | 9. AGE (last birthday) 55 |
| 13a. FATHER'S NAME William Bostic | | 13b. MOTHER'S MAIDEN NAME Hallie Jacient | 11. BIRTHPLACE (City and state or country) Mayfield, Ky. |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 95 | |
| 17. INFORMANT Lorine Garland, Unity, Ill. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. - DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Arteriosclerotic Heart Disease with congestive failure. | | | 14. NAME OF HUSBAND OR WIFE Deceased |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Edema | | | 17. INFORMANT Address Lorine Garland, Unity, Ill. |
| 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.) | |
| 20c. TIME OF INJURY Hour 11:28 p.m. Month, Day, Year 3-10-63 | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION Cape Girardeau, Mo. | |
| 21. I attended the deceased from 3-10-63 to 3-10-63 and last saw her ^{her} _{him} alive on 3-10-63 | | 22c. DATE SIGNED 3/13/63 | |
| 22a. SIGNATURE <i>J. H. Kern M.D.</i> (Degree or title) | | 22b. ADDRESS 230 N. Sprigg | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 3-17-63 | |
| 23c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery | | 23d. LOCATION (City, town, or county) Mounds, Illinois | |
| 24. FUNERAL DIRECTOR Avant Funeral Home, Cairo, Ill. | | 25. DATE RECD. BY LOCAL REG. 3-18-63 | |
| 26. REGISTRAR'S SIGNATURE <i>Jim Kasten</i> | | | |

APR 11 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 Mabel L. Donaldson Tuont X

Licensed Embalmer No. 31-4406 X

P. O. Address Box 375 X

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.