

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-011028

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 096 Primary Registration District No. _____ Registrar's No. 20

FILED MAR 26 1963

1. PLACE OF DEATH a. COUNTY <u>Dallas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wilson</u>		Length of stay in lb <u>life</u>	c. CITY OR TOWN <u>Long Lane, Mo.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Long Lane, Mo.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Long Lane, Mo.</u>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Smith</u>		DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1963</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1868</u>
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>—</u>	9. AGE (last birthday) <u>94</u>
11. BIRTHPLACE (City and state or country) <u>Dallas County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Arson Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Wilson</u>	14. NAME OF HUSBAND OR WIFE <u>Arnie B. Smith</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>		17. INFORMANT Arnie B. Smith Long Lane, Mo.	
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>Coronary thrombosis</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u>Chronic Bronchitis & Scabity</u>			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 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>5</u> <u>1960</u> to <u>3-2-63</u> and last saw him alive on <u>3-1-63</u> Death occurred at <u>5 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <u>Charles O. Gammann M.D.</u>		22b. ADDRESS <u>Buffalo Mo.</u>	22c. DATE SIGNED <u>3-5-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-4-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Dallas County Mo.</u>
24. FUNERAL DIRECTOR <u>Montgomery Funeral Home, Buffalo, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3/23/63</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Vern Kline SR.</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY-AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

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Rev. 4/59

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MAR 28 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

Ayle Montgomery

Licensed Embalmer No. 73592

P. O. Address Buffalo, S.D.

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.