

37831

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 10 1956

STATE FILE NUMBER

Registration District No. 142 Primary Registration District No. 6786 Registrar's No. 30

1. PLACE OF DEATH a. COUNTY <u>Hawaii</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>			
b. CITY (If outside corporate limits of Town or City) <u>Mountain View, Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Mountain View</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>St. Francis Hosp - Hour</u>				Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>None</u>	
3. NAME OF DECEASED (Type or print) <u>Bishop MARVIN SMOTHERMAN</u>				First Middle Last		4. DATE OF DEATH <u>Dec. 1, 1956</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 type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 7, 1884</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>72</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph G. Smotherman</u>				14. MOTHER'S MAIDEN NAME <u>Sarah J. Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>497-34-9002</u>		17. INFORMANT <u>Lyle Smotherman</u> Address <u>1400 PARKWAY ST. K. C. MO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DISEASE WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Arteriosclerotic Heart Disease</u>		DUE TO (c) <u>H2O.0</u>		months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							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 <u> </u> Month <u> </u> Day <u> </u> , Year <u> </u> a. m. <u> </u> p. m. <u> </u>							
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>12/1/56</u> to <u>12/1/56</u> and last saw ^(non-him) alive on <u>12/1/56</u> Death occurred at <u>9:30</u> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>Medical Clinic, Willow Springs, Mo</u>		22c. DATE SIGNED <u>12/1/56</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>12-5-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Teresita, Mo</u>		
24. FUNERAL DIRECTOR <u>DUNCANS - Mtr. View Mo.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>12-7-1956</u>		26. REGISTRAR'S SIGNATURE <u>Laura Hitchell</u>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service
300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *Joe R. Duncan*

Licensed Embalmer No. *43*

P. O. Address *Mt. View*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.