

FILED JUL 3 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21662**

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6075 Registrar's No. 234

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Francois</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Ste. Genevieve</u> |   |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Francois Twp.</u> ) |  | c. CITY OR TOWN <u>Farmington</u>  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <u>RD</u> |
| c. LENGTH OF STAY (in this place) <u>9M; 25 das.</u>  |  | f. STREET ADDRESS (If rural, give location) <u>Route 3</u>   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri State Hospital No. 4</u>                  |  |  |   |

|                                     |                                |                       |                        |  |
|-------------------------------------|--------------------------------|-----------------------|------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>LABE (LABEN)</u> | b. (Middle) <u>C.</u> | c. (Last) <u>SMITH</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>June 25, 1956</u> |
|-------------------------------------|--------------------------------|-----------------------|------------------------|--|

|                    |                               |   |                                       |   |  |   |
|--------------------|-------------------------------|---|---------------------------------------|---|--|---|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Feb. 27, 1875</u> | 9. AGE (In years last birthday) <u>81</u> | IF UNDER 1 YEAR Months <u>3</u> Days <u>28</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
|--------------------|-------------------------------|---|---------------------------------------|---|--|---|

|  |                                   |   |  |
|--|-----------------------------------|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) <u>Ste. Genevieve Co., Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|--|-----------------------------------|---|--|

|                                      |   |   |
|--------------------------------------|---|---|
| 13a. FATHER'S NAME <u>Wash Smith</u> | 13b. MOTHER'S MAIDEN NAME <u>Lavina Baysinger</u> | 14. NAME OF HUSBAND OR WIFE <u>Ethel</u> (2nd wife) |
|--------------------------------------|---|---|

|  |  |   |         |
|--|--|---|---------|
| 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>Unknown</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Records, State Hospital No. 4, Farmington, Mo.</u> | ADDRESS |
|--|--|---|---------|

|  |  |  |                                  |
|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i> | MEDICAL CERTIFICATION  |  | INTERVAL BETWEEN ONSET AND DEATH |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Terminal pneumonia, - - - - -</u>  |  | <u>Abt. 4 das.</u>               |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Inanition - - - - -</u> |  | <u>Abt. 6 mos.</u>               |
| II. OTHER SIGNIFICANT CONDITIONS <u>Chronic brain syndrome with cerebral arterio-sclerosis with psychotic reaction.</u>  |  |  |                                  |

|                        |                                  |  |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

|  |  |                            |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from August 30, 1955, to June 25, 1956, that I last saw the deceased alive on June 25, 1956, and that death occurred at 4:20 a.m., from the causes and on the date stated above.

|  |   |                                 |
|--|---|---------------------------------|
| 23a. SIGNATURE <u>John W. Brennan MD</u> (Name or title) | 23b. ADDRESS <u>State Hospital No. 4, Farmington, Mo.</u> | 23c. DATE SIGNED <u>6-25-56</u> |
|--|---|---------------------------------|

|   |                          |  |   |
|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Byrial</u> | 24b. DATE <u>6-27-56</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill Cemetery</u> | 24d. LOCATION (City, town, or county) (State) <u>Ste. Genevieve Co., Missouri</u> |
|---|--------------------------|--|---|

|  |  |  |         |
|--|--|--|---------|
| DATE REC'D BY LOCAL REG <u>June 25, 1956</u> | REGISTRAR'S SIGNATURE <u>Ethel Rudloff</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Gozean Funeral Home, Farmington, Mo.</u> | ADDRESS |
|--|--|--|---------|

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

289

**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..... *C. H. Cozart*

Licensed Embalmer No. *4084*

P. O. Address *Farmington*

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.