

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

40732

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Wau Primary Registration District No. 200
 City Kansas City (No. Kansas City Gen. Hosp. St. _____ Ward)

File No. 1500
 Registered No. 2100

2. FULL NAME

Richard Smith
 (a) Residence. No. 1107 Central St. 1 Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>3-19-1863</u>		
7. AGE YEARS <u>66</u>	MONTHS <u>8</u>	DAYS <u>24</u>
If LESS than 1 day, _____ hrs. or _____ min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Stationary Engineer</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-13 1929

17. I HEREBY CERTIFY, That I attended deceased from 8-15, 1929 to 12-13, 1929 that I last saw him alive on 12-12, 1929 and that death occurred, on the date stated above, at 5:00 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bulbar Palsy
81A

CONTRIBUTORY (SECONDARY) 173W (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED OF DISEASE? in findings
12-13 (Signed) P. O. Williams, M. D.
 (Address) Gen. Hosp. KC Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo.

10. NAME OF FATHER Michael H. Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Mary Soderen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ireland

14. INFORMANT Reward Clerk
 (Address) K. C. General Hosp.

15. FILED 12/13/29 M. M. Crowe REGISTRAR
Wor

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Marys Cemetery DATE OF BURIAL Dec 14 1929

20. UNDERTAKER Dr. Newcomer ADDRESS 211 E 9th

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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