

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

Do not use this space.

**32238**

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
Township Kaw Primary Registration District No. \_\_\_\_\_  
City K. C. Mo (No. Research Hospital)

File No. \_\_\_\_\_  
Registered No. 3764  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. Madison, Kans. Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 21st 1849  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 83 6 15  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. retired farmer  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Angie C. Smith

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know Iowa

13. NAME G. W. Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know Ia

15. MAIDEN NAME Shoemaker

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT Mrs. Neva Horton  
(ADDRESS) Madison, Kas.

18. BURIAL, CREMATION, OR REMOVAL PLACE Madison Kas. DATE 10-9-32

19. UNDERTAKER Porter & Sons  
(ADDRESS) 915 N. 10th St. K.C. Mo

20. FILED 10-7-1932 M. M. Corvine  
Regist.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 6, 1932

22. I HEREBY CERTIFY, That I attended deceased from Sept 8, 1932, to Oct 6, 1932

I last saw him alive on Oct 6, 1932. Death is said to have occurred on the date stated above, at 4:45 pm.

The principal cause of death and related causes of importance were as follows:

Pulmonary embolism Date of onset \_\_\_\_\_

512 1350 1110

Other contributory causes of importance: Suppurative cystitis

Name of operation Suppurative cystitis Date of Sept 16-32

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? 11/20/32

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

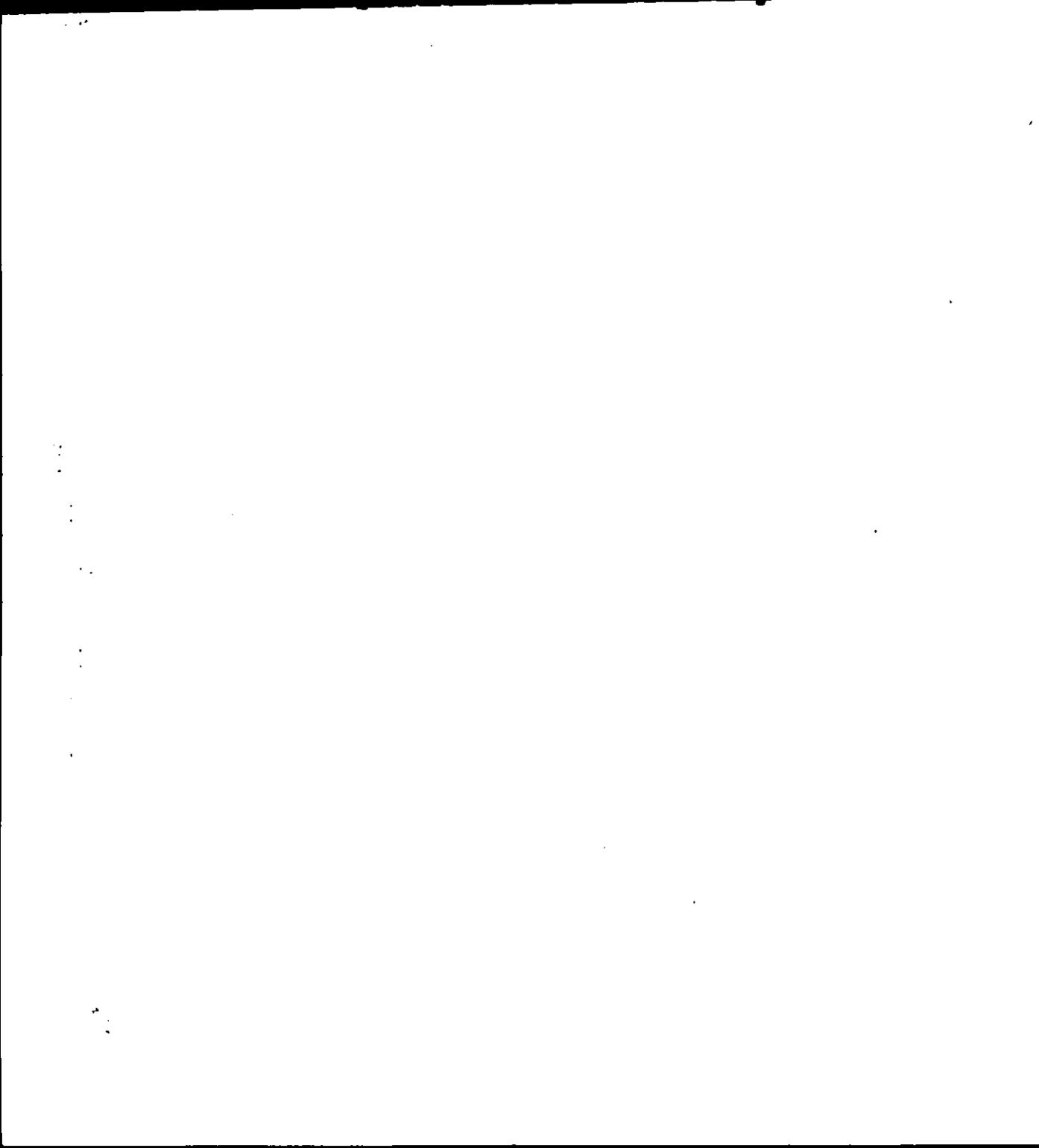
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_

(Signed) M. M. Corvine M. D.

(Address) 1019 Doyle K.C. Mo

N. 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.



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County.....

Registration District No. 399

Township.....

Primary Registration District No. 1002

City X City (No. ....)

File No. ....

Registered No. 8764

St. .... Ward)

**2. FULL NAME**

(a) Residence, No. Jacob S. Smith St. .... 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19...

19. UNDERTAKER (ADDRESS)

20. FILED 10/7 1932 M. M. Browe Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 6 - 1932

22. I HEREBY CERTIFY, That I attended deceased from

to 19...

I last saw him alive on 19... Death is said

to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Pulmonary Embolism Date of onset

Other contributory causes of importance:

Superficial Cystotomy

For prostatic obstruction

Hæmorrhage of prostate

Name of operation Date of

What test confirmed diagnosis? Ca. of prostate Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. M. McCann, M. D.

(Address) 1019 Maple R. Reno

**SUPPLEMENTARY**

510

N. 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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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