

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

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

1077
Do not use this space.

REC'D FEB 20 1939

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Raw Primary Registration District No. 1027
 (c) City K. C., Mo (d) Street No. Trinity Lutheran Hospital Registered No. 90
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John E. Smith
 (a) Residence, No. 4520 Rainbow Blvd St. Kans City Ks
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Margaret Smith
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3/12/1876
 7. AGE YEARS 62 MONTHS 9 DAYS 25 If LESS than 1 day, hrs. or min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Employed
 9. Industry or business in which work was done, as saw mill, bank, etc. Rudolph Baker
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation Co.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-7, 1939
 22. I HEREBY CERTIFY, That I attended deceased from January 1, 1939, to January 7, 1939
 I last saw him alive on January 7, 1939. Death is said to have occurred on the date stated above, at 11:12 p.m.
 The principal cause of death and related causes of importance were as follows:

Bilateral Lobar Pneumonia
 Date of onset Jan 1, 39

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
 FATHER
 13. NAME Jacob Smith
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
 MOTHER
 15. MAIDEN NAME Anna Myers
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
 17. INFORMANT (ADDRESS) Mrs Margaret Smith
4520 Rainbow Blvd.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Moberly, Mo. DATE Jan 8, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stine-McClure
Kansas City, Mo.
 20. FILED Jan 8, 1939 M. M. Brown
 Local Registrar.

Other contributory causes of importance:
Chronic Asthma

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____
 Cause of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) G. D. Salayor M. D.
 (Address) 1901 S. W. Blvd., K.C., Ks.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.