

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

1312  
 Do not use this space.

REC'D FEB 20 1939

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. 2646 Victor St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (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 563 Mrs. Mary Berryman Smart  
 (a) Residence, No. 2646 Victor St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female  
 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 James G. Smart

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 21, 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
76 9 2

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. At home  
 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) Independence Missouri

FATHER  
 13. NAME Watt Royster

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

MOTHER  
 15. MAIDEN NAME Miss Sally A. Scruggs

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

17. INFORMANT (NAME) (ADDRESS) Mr. James G. Smart (Husband)  
2646 Victor, Kansas City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Woodlawn Cemetery  
Independence, Mo. DATE Jan. 24 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stine & McClure  
Kansas City, Missouri.

20. FILED Jan 25 1939 M. M. Crowe  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 23 1939

22. I HEREBY CERTIFY, That I attended deceased from July 21, 1936, to Jan 23, 1939  
 I last saw her alive on Jan 23, 1939. Death is said to have occurred on the date stated above, at P. m. 4:05  
 The principal cause of death and related causes of importance were as follows:

Myocarditis, chronic  
50

Other contributory causes of importance:  
 ① Aneurysm of aorta ?  
 ② Fractured hip  
 ③ Tumor of breast - carcinoma ?  
 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? No 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) Lyman Richardson M. D.  
 (Address) 906 Grand, 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.

1000  
V  
11

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No..... Registered No. 325  
 (c) City..... (d) Street No..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (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 Mrs Mary Bergman Smith

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX ♀ 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 23, 1937

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

22. I HEREBY CERTIFY That I attended deceased from 19... to ... 19...  
 I last saw h..... alive on ..... 19... Death is said to have occurred on the date stated above, at ..... m.

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
76

Chronic myocarditis Date of onset ?

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

Other contributory causes of importance:  
1) narrowing of aorta  
2) fracture of hip Dec. 20, 1937  
3) coronary B. block  
 Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? No

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 25 1937 M. M. Cross  
 Local Registrar.

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

(Signed) Lynman Richardson M. D.  
 (Address) 906 Grand K.C. Mo.

SUPPLEMENTARY

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 COMPLETED AS PRESCRIBED BY LAW.

S-1312