

WRITE PLAINLY—USE UNFADING INK
 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.

FILED APR 12 1940

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MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. _____

9551

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

985

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Cam
 (c) Name of hospital or institution Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 1/2 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Albert T. Smith

8. (b) If veteran, name war _____

Albert T. Smith

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Cara A. Smith

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Aug 15 - 1892

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

67

6

17

hr. min.

9. Birthplace

(City, town or county)

(State or foreign country)

Jama

10. Usual occupation

Business Developer

11. Industry or business

Self

12. Name

Alexander Smith

13. Birthplace

(City, town, or county)

(State or foreign country)

Jackson

14. Maiden name

(City, town, or county)

(State or foreign country)

Unknown

15. Birthplace

(City, town, or county)

(State or foreign country)

Jackson

16. (a) Informant's own signature

Leonard F. Smith

(b) Address

4851 East 18th

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof

Mar 5 40 (Month) (Day) (Year)

(c) Place: burial or cremation

Elmwood Cem

18. (a) Signature of funeral director

Rose Hudson

(b) Address

4851 East 18th

19. (a) 3-3-40 (Date received local registrar)

(b)

M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4851 East 18th
 (If rural, give locality)
 (e) If foreign born, how long in U. S. A.? Life years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2
 year 1940 hour 3 minute 50 A. M.

21. I hereby certify that I attended the deceased from Mar 1, 1940 to Mar 3, 1940
 that I last saw him alive on Mar 1, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death

Myocarditis

Duration

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Myocarditis

Of autopsy

no

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no
 (b) Date of occurrence no
 (c) Where did injury occur? no (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place)

(e) Means of injury no

23. Signature J. J. Mackey (M. D. or other)

Address Kansas City Mo Date signed 3-3-40

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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.....

Van Lammox - (Apprentice), Registered Apprentice No.....
working under my personal supervision.

Signed.....

John B. Camp

Licensed Embalmer No. *29655*

P. O. Address..... *K.C. Mo*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 985

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Eberet D. Smith

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				hr. min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3/3/40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 2 year -40
hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to _____

Due to Chronic interstitial

Other conditions Nephritis
(Include pregnancy within _____ months of death)

Major findings: 121

Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature J. F. Mackey (M. D. or other) _____

Address _____ Date signed _____

S-9551