S. No. 2
—11-10-39
. 5-17-39
I. X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17494

JN 17 1940

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 2021

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City 9
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1316 Vine St. - Apartment 6
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 3 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1316 Vine St. - Apt. 6
(If rural, give location)

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

3. (a) PRINT FULL NAME Bertha Smith 530

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife Frank Smith

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased February (Month) 27 (Day) 1894 (Year)

8. AGE: Years 46 Months 2 Days 16 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Mose Pertiller
13. Birthplace Forman (City, town, or county) Arkansas (State or foreign country)

MOTHER
14. Maiden name Matilda Kountz
15. Birthplace Forman (City, town, or county) Arkansas (State or foreign country)

16. (a) Informant Frank Smith
(b) Address 1316 Vine St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-40 (Month) (Day) (Year)
(c) Place: burial or cremation Blue Ridge Lawn Cem.

18. (a) Signature of funeral director West, Appleton & Jones
(b) Address 1905 Vine St.

19. (a) May 15, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 13
year 1940 hour 7 P minute P M.

21. I hereby certify that I attended the deceased from 5-2, 1940 to 5-13, 1940
that I last saw her alive on 5-13, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Ascites & Oedema of Lower Extremities

Due to Cochin - Nephritis Chronic

Due to 95 B2

Other conditions Intestinal Obstruction
(Include pregnancy within 3 months of death)
Due to Constipation

Major findings:
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)
Address 1509 E 1 Fax Date signed 5/14/40

(Licensed Embalmer's Statement on Reverse Side)

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 C. H. West

Licensed Embalmer No. 2710

P. O. Address 1905 Vine St.

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.