

Registration District No. 3399

Primary Registration District No.

1002

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K. C. General Hospital No. 1
(If not in hospital or institution, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)
In this community 60 Years

3. (a) PRINT FULL NAME Olive Della Smith 530

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mr. James S. Smith 6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased September 9 1870
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 8 25 hr. min.

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

10. Usual occupation At Home

11. Industry or business -----

MOTHER FATHER { 12. Name John Wycoff

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

14. Maiden name Rachel Cabaen

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

16. (a) Informant Mrs. May Anderson

(b) Address Eldorado, Kansas

17. (a) Burial (b) Date thereof June 6, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director O. K. Newsome's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) June 5, 1940 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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. 2021 Independence Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? ----- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8th
year 1940 hour 5 minute 55 A. M.

21. I hereby certify that I attended the deceased from June 1st 1940 to June 4th 1940 ;
that I last saw her alive on June 4th, 1940 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Status asthmaticus and purulent Bronchitis

Due to 10 1/2 P

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: -Of operations

Of autopsy See above

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 R. J. DuMarshall (M. D. or other) Supt. K. C. Gen. Hospital, K. C. Mo.
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Emile M. Calhoun

Licensed Embalmer No. 3506

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.