No. 2
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17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 14 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24131
2744

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No.

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: The Polyclinic Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 Hours (Specify whether years, months or days)

In this community Lifetime

530

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. 1727 West 71st Street (If rural, give location)

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

3. (a) PRINT FULL NAME Mr. Dorald Warren Smith

8. (b) If veteran, name war No

3. (c) Social Security No 495-09-1669

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased August (Month) 6 (Day) 1913 (Year)

8. AGE: Years 26 | Months 10 | Days 297 | If less than one day ____ hr. ____ min.

9. Birthplace Kansas City (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Machinery Salesman 0

11. Industry or business Machine Rental & Sales Co 0

MOTHER FATHER

12. Name Warren O Smith

13. Birthplace Saline County (City, town, or county) Missouri (State or foreign country)

14. Maiden name Lulu Foster

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

16. (a) Informant Mrs W. O. Smith

(b) Address 2445 Spruce

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director A. H. Newcomer's Son

(b) Address 1401 Brush Creek Blvd.

19. (a) July 8, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5th year 1940 hour 1 minute 07 P. M.

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

Immediate cause of death: Auto traumatism

Due to: Subdural hematoma (bilateral)

Due to:

Other conditions (Include pregnancy within 3 months of death): 0

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) Accident

(b) Date of occurrence 7-5-40

(c) Where did injury occur? Near Parkville (City or town) Mo (County) (State)

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

While at work? (Specify yes or no) (e) Means of injury

23. Signature Arthur M. Miller (M. D. or other)

Address K. C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

210 m
98

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 H B Newcomer Jr

Licensed Embalmer No. 4043

P. O. Address K C Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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

o. 2B
21-40
X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 2744

SUPPLEMENTARY

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)

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.

3. (a) PRINT FULL NAME Donald W. 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 R

6. (b) Name of husband or wife

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

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

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 5 day - 40
year 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 Auto traumatism

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Driver lost control of car 5 left Highway 210 M 28

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) Accd

(b) Date of occurrence 7-5-40

(c) Where did injury occur? Near Parkville Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
45th Way #71
(Specify type of place)

While at work? no (e) Means of injury Auto Accident

23. Signature (M. D. or other)

Address Date signed

5-24134