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

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

30 AUG 14 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24303

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 2913

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: Trinity Hospital 9 Days (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community 9 Days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair

(c) City or town Appleton City (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 Dr. Rollin John Smith 530

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased January (Month) 18 (Day) 1861 (Year)

8. AGE: Years 79 Months 6 Days 2 If less than one day hr. min.

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

10. Usual occupation Medical Doctor

11. Industry or business In St. Clair County

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

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

16. (a) Informant Mrs. D. C. Sarfaty
(b) Address Oklahoma City Okla

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof July 20, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Appleton City, Mo.

18. (a) Signature of funeral director D. H. Newcomers Sons
(b) Address 1401 Brush Creek Blvd.

19. (a) July 21, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20 year 1940 hour 12 minute 10 P.M.

21. I hereby certify that I attended the deceased from July 11 - 1940, 19 , to July 20 - 1940 that I last saw him alive on July 20, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death
① Hypertension
② Senility
③ Arteriosclerosis
④ Prostatic obstruction

Due to 137

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Prostatic hypertrophy

Of autopsy none

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 Nelson F. Ockerlund (M. D.)
Address 1103 Grand Ave Date signed 7/20/1940

(Licensed Embalmer's Statement on Reverse Side) K.C. Mo

Dr: Nelse F
Ockerb
1530 Prof. Bl
till 3 P.

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. O. Newcomer Jr

Licensed Embalmer No. 4243

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.