

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27485**
3118
Registrar's No.

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No.

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:
3834 Garfield
(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 or 4 Yrs.
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. 3834 Garfield
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME MABEL O. SMITH 530

3. (b) If veteran, name war No 3. (c) Social Security No. No

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

6. (b) Name of husband or wife Arthur P. Smith 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Aug 16 1878
(Month) (Day) (Year)

8. AGE: Years 62 Months 6 Days 13 If less than one day hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Jones Hooper

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

14. Maiden name Walt

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

16. (a) Informant Margaret Williams
(b) Address 3834 Garfield

17. (a) Removal (b) Date thereof 8/3/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Atchison, Mo

18. (a) Signature of funeral director Maybrey Turner
(b) Address 2315

19. (a) Aug. 4, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day 8 1940
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I last saw him _____ 19____
and he died on the date and hour stated above.

Immediate cause of death Acute pulmonary congestion
Pericardial atrophy of the heart
Coronary sclerosis
Duration _____

Other conditions 9513
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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)
23. Signature Walter H. Miller (M. D. or other)
Address K. C. Mo Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

Ray E. Snow

Licensed Embalmer No.

2560

P. O. Address

1807 East 29th

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.