

No. 2
11-10-30
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27544**
Registrar's No. **3177**

SEP 5 1940
Registration District No. **399**

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:
St. Luke's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution since 7-21-40
In this community 2 1/2 years (Specify whether 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. 6449 Overbrook Road
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 20 years

3. (a) PRINT FULL NAME Mrs. Ethel Childress Smith, 530

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

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

6. (b) Name of husband or wife J. Neil Smith 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased July 26 1910
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>30</u>	<u>0</u>	<u>14</u>	hr. min.

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

10. Usual occupation at home

11. Industry or business X

MOTHER FATHER { 12. Name Pléas L. Childress
13. Birthplace Texas
(City, town, or county) (State or foreign country)
14. Maiden name Nettie Henderson
15. Birthplace Texas
(City, town, or county) (State or foreign country)

16. (a) Informant J. Neil Smith
(b) Address 6449 Overbrook Rd., K. C., Mo.

17. (a) Removal (b) Date thereof 8-10-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ozona, Texas

18. (a) Signature of funeral director Stine & McClure
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) Aug. 9, 1940 (b) M. M. Croove
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9th
year 1940 hour 6:08 minute A. M.

21. I hereby certify that I attended the deceased from July 6
1940, to Aug 9, 1940
that I last saw her alive on Aug 8, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Subacute yellow atrophy of the liver
Due to unknown
Due to 2 months

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy Subacute yellow atrophy of the liver
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?
3/1 (Specify type of place) While at work? (e) Means of injury
23. Signature Ellis M. Kellhelmy (M. D. or other)
Address Plaza med Bedg Date signed 8-9-40

Dr. Wilhelmy

401533

1974

Plaza Med. Bldg

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 E. M. Plank

Licensed Embalmer No. 1848

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27544
Registrar's No. 31770

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County Jackson K.C.
(b) City or town K.C.
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Cathel P. Smith
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one year
30 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9/9/40 (b) M. M. Corowe
(Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH: Month Aug day 9-4 year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____; that I last saw him _____ alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death Sub acute yellow atrophy of liver - 2 mo
Due to _____
Due to Patient developed no symptoms until about 6 mo after a normal delivery - no toxic state during pregnancy
Other conditions (Include pregnancy within 3 months of death)
Major findings of operations _____
Of autopsy _____

Duration
2 mo
PHYSICIAN
Underline the cause to which death would 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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature Ellis Villalobos (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

