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21492

SEP 1940
Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(c) Name of hospital or institution:
General Hosp. #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 Yrs. (Specify whether years, months or days)
In this community Robert Lee Smith 571

3. (a) PRINT FULL NAME Smith, Robt. Lee

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

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife Unknown 6. (c) Age of husband or wife if alive -- years
7. Birth date of deceased June 4 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days 13 If less than one day hr. min.

9. Birthplace Lexington Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation Farmer & Oil Business

11. Industry or business

MOTHER FATHER
12. Name C. O. Smith
13. Birthplace Va. (City, town, or county) (State or foreign country)
14. Maiden name Mary E. Withers
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Madge Watts

(b) Address K.C. Mo. Li-7667

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-40 (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville Mo.

18. (a) Signature of funeral director [Signature]

(b) Address Higginsville Mo.

19. (a) Aug. 18 1940 (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
4541 Prospect
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17 year 1940 hour 10:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from August 10, _____, 1940, to August 17, 1940;
that I last saw h. a. t. a. alive on August 17, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration
Gonorrhea cystitis 1 week
Ascending pyelonephritis 1 month
Due to Alta cirrhosis of liver
Due to Myocardial infarction with
hypertension
Other conditions 12463
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy As 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)
(e) Means of injury 1
23. Signature Ed H. Klein (M. D. or other) _____
Address K.C. General Hosp. Date signed 8/18/40

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

Apprentice

3

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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

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