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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31137

Registrar's No. 3700

Registration District No. 399 Primary Registration District No. 1002

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 2 months, (Specify whether years, months or days)

In this community Unknown,

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.: 840 West 57th Terrace,
(If rural, give location)

(e) If foreign born, how long in U. S. A.? No. years.

3. (a) PRINT FULL NAME: Mrs. Esther Smyth Langsdale,

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: Clif Langsdale,

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

7. Birth date of deceased: April (Month) 6 (Day) 1888 (Year)

8. AGE: Years 51 Months 5 Days 15 If less than one day hr. min.

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

10. Usual occupation: at home,

11. Industry or business: x

FATHER
12. Name: Fred G. Smyth,
13. Birthplace: Wisconsin, (City, town, or county) (State or foreign country)

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

16. (a) Informant: Clif Langsdale,
(b) Address: 840 West 57th Ter., K. C., Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-23-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Forest Hill Abbey,

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

19. (a) 9-23-40 (Date received local registrar) (b) M. M. Grosme (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 21st, year 1940 hour 8:15 minute P. M.

21. I hereby certify that I attended the deceased from June 20, 1940, to Sept 21, 1940, that I last saw her alive on Sept 21, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Multilocular cystadenoma of ovary with metastasis to peritoneum of	4 months
Due to: intestinal tract, liver & retroperitoneal structures	@least
Due to: 1/19	
Other conditions (Include pregnancy within 3 months of death): Pelvic phlebitis (Thrombo) & Left pulmonary infarction	4 wks

Major findings:
Of operations:
Of autopsy: Confirmed clinical diagnosis

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: P. T. Bohan (M. D.)
Address: 315 Alameda Road Date signed: 9-23-40

(Licensed Embalmer's Statement on Reverse Side)

Dr. P. T. Bohan,
Med Recy C Body
2:30

I

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 J B Waters

Licensed Embalmer No. 3992

P. O. Address K C Mo

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.