

No. 2
1-13-40
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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

REC'D JAN 8 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41342

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4735

1. PLACE OF DEATH: **Jackson**
(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: **K. C. General Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 hours**
In this community **No record**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME: **W. H. Smith (N.M.O.)**
3. (b) If veteran, name war: **None**
3. (c) Social Security No.: **No record**

4. Sex: **Male**
5. Color or race: **White**
6. (a) Single, widowed, married, divorced: **No record**

6. (b) Name of husband or wife: **No record**
6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: **No record**
(Month) (Day) (Year)

8. AGE: Years **76** Months **no record** Days **no record**
If less than one day hr. min.

9. Birthplace: **No record**
(City, town, or county) (State or foreign country)

10. Usual occupation: **No record**

11. Industry or business: _____

12. Name: **No record**

13. Birthplace: **No record**
(City, town, or county) (State or foreign country)

14. Maiden name: **No record**

15. Birthplace: **No record**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Record clerk**

(b) Address: **K. C. Gen. Hospital, K. C. Mo.**

17. (a) **Removal** (b) Date thereof: **12-12-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: **Kirksville, MO.**

18. (a) Signature of funeral director: **Wailart Funeral Home**

(b) Address: **2352 Monitor Place, K. C. Mo.**

19. (a) **12-12-40** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
Missouri
(b) County: **Jackson**
(c) City or town: **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No.: **548 Main St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **7th**
year **1940** hour **6** minute **25** P. M.

21. I hereby certify that I attended the deceased from **12-7-40**, 19____, to **12-7-40**, 19____,
that I last saw him alive on **12-7-40**, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death: **CEREBRAL HEMORRHAGE**

Due to: _____

Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: **None**

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: **Henry R. Show** (M. D. or other)

Address: **Med. Director K. C. Gen. Hospital** Date signed _____

Duration

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

Blaine E. Walcott

Licensed Embalmer No.

4075

P. O. Address

2332 Winton Pl.

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, fact should be so stated above.