

**JAN 8 1941**  
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 5026

**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:  
2915 Lockridge Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution ---  
(Specify whether  
In this community 66 Years  
years, months or days)

3. (a) PRINT FULL NAME Mr. Charles H. Smith

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Mrs. Smith 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased January 13 1867  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>11</u>	<u>18</u>	<u>hr. min.</u>

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

10. Usual occupation Salesman

11. Industry or business Bakery

12. Name James H. Smith

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

14. Maiden name Unknown

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

16. (a) Informant Jack Roberts  
(b) Address 2915 Lockridge

17. (a) Burial (b) Date thereof Jan. 2, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director D. H. Newcomer Sons

(b) Address 1401 Brush Creek lvd.

19. (a) 12-31-40 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

MOTHER, FATHER

**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. 2915 Lockridge Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? --- years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month December day 31st  
year 1940 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from Oct. 27, 1940, to Dec. 31, 1940; that I last saw him alive on Dec 30, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Broncho-pneumonia Duration 4 days

Due to Hypertensive myocardial degeneration 1 week

Due to Hypertension & cerebral hemorrhage 11 weeks

Other conditions (include pregnancy within 3 months of death) 93c

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature John M. Powers (M. D. or other) MD

Address 332 1/2 E. 27th St Date signed 12/31/40

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address D.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.