

No. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27376**
Registrar's No. **3034**

FILLED SEP 12 1941
Registration District No. **277**

Primary Registration District No. **1007**

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: **General Hospital #2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8-4-41-8-11-41**
(Specify whether years, months or days) **40 years**

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. **1114 Belvedere**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **INDIA SMITH**

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

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **January 2 1875**
(Month) (Day) (Year)

8. AGE: Years **66** Months **7** Days **9** If less than one day hr. min.

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

10. Usual occupation **Unemployed**

11. Industry or business _____

MOTHER FATHER { 12. Name **undisclosed**
13. Birthplace **undisclosed**
14. Maiden name **Miss Thomas**
15. Birthplace **Mississippi**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**
(b) Address **General Hospital #2**

17. (a) **Burial** (b) Date thereof **8-14-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **West Lawn**

18. (a) Signature of funeral director **H. B. Moore**
(b) Address **711 1920 E. 18th St**

19. (a) **9/11/41** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **11th**
year **1941** hour **12** minute **30** a.m.

21. I hereby certify that I attended the deceased from **8-4-41** 19__ to **8-11-41** 19__;
that I last saw her alive on **8-11-41** 19__
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive type Heart Disease** Duration _____

Due to **Possible cerebral Thrombosis**

Due to _____
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations **g. s. a.**
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 **G. A. Brown** (M. D. or other) _____
Address **Gen Hosp #2** Date signed **8/11/41**

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 ML

....., Registered Apprentice No.
working under my personal supervision.

Signed AB Meoria

Licensed Embalmer No. 2410

P. O. Address. 120 E 18th

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.