No. 2
1-4-41
17-39
X28390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 37536

DEC 22 1941

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4331

48

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

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: Ashland Hotel
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: ADAM SMITH
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Divorced
6. (b) Name of husband or wife: Unknown
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: June 1st 1870 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
71	5	18	hr. min.

9. Birthplace: Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: None
11. Industry or business:
MOTHER FATHER
12. Name: William Smith
13. Birthplace: Missouri (City, town, or county) (State or foreign country)
14. Maiden name: Emma Fields
15. Birthplace: Tenn. (City, town, or county) (State or foreign country)
16. (a) Informant: Record Clerk
(b) Address: K.C. General Hospital
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 11 22 41 (Month) (Day) (Year)
(c) Place: burial or cremation: St. Louis, Missouri
18. (a) Signature of funeral director: Gailert Funeral Home
(b) Address: 2532 Monitor Pl. K. C. Mo.
19. (a) 11-22-41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19th year 1941 hour 11 minute 45 A. M.
21. I hereby certify that I attended the deceased from 11-18-41, 19__, to 11-19-41, 19__; that I last saw him alive on 11-19-41, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lung Abscess & Bronchopneumonia	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: See above	

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: Amery R. Thom (M. D. or other)
Med. Dir. K.C. Gen. Hospital
Address: Date signed:

(Licensed Embalmer's Statement on Reverse Side)

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. Weaver

Licensed Embalmer No.....4075

P. O. Address 2332 Monitor Pl.

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

If this body is not embalmed, fact should be so stated above.