

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
2618 East 9th St.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. 1  
(Specify whether years, months or days)  
 In this community 35 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City, Mo.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2618 East 9th St.  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 3 1941  
 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 6-9 1941  
 that I last saw him alive on \_\_\_\_\_ 1941  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Acute coronary occlusion

Due to \_\_\_\_\_  
 Due to 94a

Other conditions  
(Include pregnancy within 9 months of death)

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

Duration

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? \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

23. Signature W. H. Crowe (M. D. or other) \_\_\_\_\_  
 Address K.C. Mo. Date signed \_\_\_\_\_

3. (a) PRINT FULL NAME Ray E E Smith SMITH

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

4. Sex M 0 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lillie Smith 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased March 30th, 1880  
(Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 3 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Railway Mail Clerk

11. Industry or business U.S. Government

12. Name Duff G. Smith

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

14. Maiden name Nancy E. Fisher

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

16. (a) Informant Mrs. Lillie Smith

(b) Address 2618 E 9th St. K.C. Mo.

17. (a) Burial (b) Date thereof Dec. 5, 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery  
Sheil Funeral Home

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address 6606 Indep. Ave. K.C. Mo.

19. (a) 12/4/41 (b) W. H. Crowe  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**