

FILED FEB 11 1942

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 1427  
Registrar's No. 166

1. PLACE OF DEATH:

(a) County. Jackson  
Kansas City  
(b) City or town.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution.  
K.C. General Hospital No. 20  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 4 days  
(Specify whether  
In this community. 31 yrs.  
years, months or days)

3. (a) PRINT FULL NAME JOHN 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. Unknown 6. (c) Age of husband or wife if alive. 23 years (Month) (Day) (Year)

7. Birth date of deceased. Nov. 23 1868  
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 18 If less than one day  
hr. min.

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

10. Usual occupation. Salesman

11. Industry or business.

12. Name. John Smith

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

14. Maiden name. Anna

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

16. (a) Informant. N. Martins

(b) Address. Wichita, Kansas

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof. 1-13-42 (Month) (Day) (Year)

(c) Place: burial or cremation. Floral Hills

18. (a) Signature of funeral director. Weilert Funeral Home (Specify type of place) while at work? (e) Means of injury.

(b) Address. K.C. Gen. Hospital

19. (a) 1-13-42 (Date received local Registrar) (b) M. M. Crowe (Registrar's signature)

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. 1010 Wyandotte  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 11th  
year 1942 hour 10 minute 10 P. M.

21. I hereby certify that I attended the deceased from 1-7-42 19 to 1-11-42 19

that I last saw him alive on 1-11-42 19 and that death occurred on the date and hour stated above.

Immediate cause of death. Chronic atherosclerosis with chronic myocardial infarction; Cardiac hypertrophy; pulmonary edema and congestion Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations. 95c<sup>2</sup>

Of autopsy. See above 95c<sup>2</sup>

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? (e) Means of injury.

23. Signature. Dwight R. Thorne (M. D. or other)

Address. Med. Dir. K.C. Gen. Hospital Date signed

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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. Weiler  
Licensed Embalmer No. 4675  
P. O. Address 2332 Monitor Place

**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.**