

No. 2
1-4-41
5-17-39
1 X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **5635**
Registrar's No. **610**

FILED MAR 9 1942
Registration District No. **130299**

Primary Registration District No. **1002**

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:
1606 Madison Street /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
in this community. **45 Years**..... (Specify whether
years, months or days)

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. **1606 Madison**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **Mr. James Edward Smith**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**
4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Clara M. Smith**
6. (c) Age of husband or wife if alive **64** years
7. Birth date of deceased **April 6 1863**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **February**, day **9**
year **1942** hour **5** minute **15 P.M.**
21. I hereby certify that I attended the deceased from **Febr 7**
1942, to **Febr 9 1942**
that I last saw him alive on **Febr 9 1942**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
78 **10** **3** hr. min.

Immediate cause of death
Cerebral haemorrhage
Due to **Chs. Sclerolysis**
Due to **degener**
Other conditions (Include pregnancy within 3 months of death) **31**
Duration **2da**
4 yrs

9. Birthplace **Joliet / Illinois**
(City, town, or county) (State or foreign county)
10. Usual occupation **Retired**
11. Industry or business **Carpenter**

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name **Unknown Smith**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign county)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign county)

16. (a) Informant **Clara M. Smith**
(b) Address **1606 Madison St**
17. (a) **Burial** (b) Date thereof **Feb 11 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Forest Hill Cemetery**

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?.....

18. (a) Signature of funeral director **D. H. Hutchinson**
(b) Address **1401 Brush Creek Blvd**
Feb 11 1942 (c) **D. M. Crowe**
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (e) Means of injury.....
23. Signature **C. M. Cooney M.D.** (M. D. or other)
Address **708 W 17th St** Date signed **2/10/42**

708 W 17th
De Council

Smith

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..... *A. C. Newcomer Jr*
Licensed Embalmer No..... *4043*
P. O. Address..... *A. C. Newcomer*

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.