

FILED MAY 21 1942
 399

Registration District No. _____

Primary Registration District No. **1002**

Registrar's No. **1870**

1. PLACE OF DEATH:
 Jackson
 (a) County
 (b) City or town **Kansas City**
 (c) Name of hospital or institution **A.C. General Hospital No. 1**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **11 day**
 In this community **22 Years**
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 Missouri Jackson **44**
 (a) State (b) County
 (c) City or town **Kansas City**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **4326 Roanoke Parkway**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country: **---**

3. (a) PRINT FULL NAME **Deloss W. Smith**
3. (b) If veteran, **No** **3. (c) Social Security** **None**
 name war No No

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **11th**
 year **1942** hour **6:00 P.M.** minute _____ M.
21. I hereby certify that I attended the deceased from
5-1-42, 19____, to **5-11-42**, 19____
 that I last saw him alive on **5-11-42**, 19____
 and that death occurred on the date and hour stated above.

4. Sex **Male** **5. Color or race** **White** **6. (a) Single, widowed, married,** **divorced** **Married**
6. (b) Name of husband or wife **Mrs. Clara Lang Smith** **6. (c) Age of husband or wife if** **62**
7. Birth date of deceased **February 7 1874**
 (Month) (Day) (Year)

Immediate cause of death **Carcinoma of Intestine**
 Due to **46E**
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years **68** Months **3** Days **4** If less than one day
 hr. _____ min. _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.
 Major findings: Of operations _____
 Of autopsy **None**

9. Birthplace **Lafayette Indiana**
 (City, town, or county) (State or foreign country)
10. Usual occupation **Retired**

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) _____

11. Industry or business _____
12. Name **Werdie W. Smith**
13. Birthplace **Ohio**
 (City, town, or county) (State or foreign country)
14. Maiden name **Melissa Johnson**
15. Birthplace **Ohio**
 (City, town, or county) (State or foreign country)

23. Signature **Amey C. Thom** (M. D. or other) _____
 Address **Med. Dir. K.C. Gen. Hospital** Date signed _____

16. (a) Informant **Mrs. Clara Lang Smith**
(b) Address **4326 Roanoke Parkway**
17. (a) - Cremation (b) Date thereof **May 12, 1942**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **D. W. Newcomer's Sons**
18. (a) Signature of funeral director **D. W. Newcomer's Sons**
(b) Address **1401 Brush Creek Blvd.**
19. (a) 5-12-42 (b) **M. M. Brown**
 (Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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 Emile W. Calhoun

Licensed Embalmer No. 3506

P. O. Address Remo

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.