

FILED FEB 25 1943
Registration District No. **149**

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: 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 Mo. & 17 days
(Specify whether years, months or days)

In this community Unknown

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. 5482 Main
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME George Smith

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 5. Color or face White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife No record 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased June 1st 1876
(Month) (Day) (Year)

8. AGE: Years 66-88 Months 7 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation None listed

11. Industry or business _____

12. Name William Smith Iowa

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

14. Maiden name No record

15. Birthplace No record
(City, town, or county) (State or foreign country)

16. (a) Informant Record clerk
(b) Address K.C. General Hospital

17. (a) Burial (b) Date thereof 2-5-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reeds

18. (a) Signature of funeral director Wm. B. Schuy
(b) Address 414 Madison

19. (a) 2-5-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 17th
year 1943 hour 6 minute 50 A.M.

21. I hereby certify that I attended the deceased from 12-1-42, 19____, to 1-17-43, 19____;
that I last saw him alive on 1-17-43, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of lung

Due to _____

Due to _____

Other conditions 47B
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy See above

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) Means of injury _____

23. Signature Dwight R. Johnson (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital Date signed _____

Duration _____
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.....

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.