No. 2
-5-42
-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 26 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

5502

State File No. .....

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 692

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: 5823 / E. 13th ST.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 40 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State MISSOURI (b) County JACKSON 3

(c) City or town KANSAS CITY 8
(If outside city or town limits, write "RURAL")

(d) Street No. 5823 E. 13th ST
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME IDA MAY SMITH

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced 2 WIDOWED

6. (b) Name of husband or wife George Smith

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Aug 14-1864 (Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 22 If less than one day ..... hr. ..... min.

9. Birthplace ..... Iowa 1
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Bert Rider
13. Birthplace no record 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name no record
15. Birthplace no record 9
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. R. H. MAGEE

(b) Address 5823 E. 13th ST.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb - 10, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hills

18. (a) Signature of funeral director Mrs C X Foster

(b) Address 918 Brooklyn KC MO

19. (a) 2-9-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 6th year 1943 hour 10 minute 10 P.M.

21. I hereby certify that I attended the deceased from June 1942 ....., 19..., to Feb 6, 1943 that I last saw her alive on Feb 6, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CARDIAC - FAILURE	
ENDOCARDITIS - GHRONIC	
Due to HYPOSTATIC CONGESTION	3 days.
Due to Senility	
Ghr NEPHRITIS	
Other conditions (Include pregnancy within 3 months of death) 131 B	

Major findings:
Of operations .....
Of autopsy .....

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? ..... (e) Means of injury .....

23. Signature Chas Stryo (M. D. or other)

Address 538 Lee Bldg. Date signed 2-9-43

361

(Licensed Embalmer's Statement on Reverse Side)

FEB 26 19

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 Me

....., Registered Apprentice No.....

working under my personal supervision.

Signed G. H. Nise

Licensed Embalmer No. 2570

P. O. Address K C Mo

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.