

FILED MAY 6 1943  
Registration District No. \_\_\_\_\_

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  
(c) Name of hospital or institution: St. Mary's Hospital  
(d) Length of stay: In hospital or institution 4 weeks  
In this community 21 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 14 East 34th St. Terrace  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mrs Kathryn Elizabeth Smith

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William T. Smith 6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased Sept. 16, 1906

8. AGE: Years 36 Months 7 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Independence, Mo.

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Kramer

13. Birthplace Independence, Mo.

14. Maiden name Catherine O'Neill

15. Birthplace Scranton, Penn.

16. (a) Informant William T. Smith

(b) Address 14 East 34th St. Terrace

17. (a) Burial (b) Date thereof April 23, 1943

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Thos. E. Quirk Funeral Home

(b) Address 4316 Troost Ave.

19. (a) 4-22-43 (b) M. M. Grove

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20th. year 1943 hour 10.45 A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 8/26/42 to 4/20/43 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolus Duration 10 Sec.  
Pelvic veins phlebitis 8 days.  
Portentation 3/20/43

Other conditions \_\_\_\_\_  
Major findings: Of operations None  
Of autopsy same as 1, 2, 3.

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

Home (Specify type of place) \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 1103 9th Date signed 4/21/43

---

---

**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.....

*John E. Zwick*

Licensed Embalmer No.....

*3775*  
*N. C. Mo*

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.**