

S. No. 2
OM-7-1-39
5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20615
Registrar's No. 2656

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: General Hospital #2 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5/7-6/9/43
In this community 21 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. 221 E. 46th St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME LAWRENCE SMITH

3. (b) If veteran, name war None 3. (c) Social Security No. 495-10-7790

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced 3 Divorced
6. (b) Name of husband or wife Myrtle Smith 6. (c) Age of husband or wife if alive Unk. years
7. Birth date of deceased April 28 1905
(Month) (Day) (Year)

8. AGE: Years 38 Months 1 Days 18 If less than one day hr. min.

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

10. Usual occupation Janitor

11. Industry or business

12. Name Robert Smith

13. Birthplace Buchanan County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Frances Whitmire

15. Birthplace Indian Territory Oklahoma
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/43
(Month) (Day) (Year)
(c) Place: burial or cremation Northlawn Cem. Watkins Bros

18. (a) Signature of funeral director Lydia
(b) Address 1729 Lydia

19. (a) 6-12-43 (Date received local registrar) (b) J. C. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 9 year 1943 hour 7 minute 15 A.M.

21. I hereby certify that I attended the deceased from May 7 1943 to June 9 1943
that I last saw him alive on June 7 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Broncho-pneumonia Duration

Due to Gangrenous cystitis with hydronephrosis

Due to 1350/10/1 1350/1

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 1350/1
Of autopsy Same as 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) (State of injury)

23. Signature J. C. Brown M.D. (M.D. or other)
Address Gen. Hosp. 22 E. 7th St. Date signed 6-11-43

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..... *I. J. Manlove*.....
Licensed Embalmer No. *3994*.....
P. O. Address: *2503 Highland*.....

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.