

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 2550

FILED JUN 24 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 Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital #2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 5/25-5/30/43  
(Specify whether \_\_\_\_\_)

In this community 12 Years  
(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. 2119 Tracy  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARJORIE SMITH

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

4. Sex Female 5. Color or Race Negro 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased August 10 1900  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>42</u>	<u>9</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace St. Joseph Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Teacher

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

MOTHER { 12. Name Joseph Smith

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

14. Maiden name Charity Booker

15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital #2

17. (a) Burial (b) Date thereof 6-4-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland

18. (a) Signature of funeral director H. Lynn Greenstreet  
(b) Address 2-1-200 E. 2nd

19. (a) 6-4-43 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30th  
year 1943 hour 10 minute 55 P. M.

21. I hereby certify that I attended the deceased from May 25, 1943 to May 30, 1943  
that I last saw him or alive on May 30, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumococic Meningitis (?)

Due to Star

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy Same as above

Duration \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_

23. Signature [Signature] (M.D. or Registrar)  
Address Law. Hall #2-600 E. 22nd Date signed 6-2-43

**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..... *W. G. Flynn* .....

Licensed Embalmer No. *2211* .....

P. O. Address. *1819 E. 18th* .....

**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.**