

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
(d) Length of stay: In hospital or institution 8 days
In this community since 1905

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. Armour Home
(e) Citizen of foreign country? no.

3. (a) PRINT FULL NAME Edward B. Smythe
(b) If veteran, name war unknown
(c) Social Security No. no.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 2 16
year 1943 hour 8 minute 20 A.M.

4. Sex Male
5. Color or Race White
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Unknown
6. (c) Age of husband or wife if alive X years
7. Birth date of deceased October 26 1859

21. I hereby certify that I attended the deceased from August 8 1943 to August 16 1943 that I last saw him alive on August 16 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia clinical

8. AGE: Years 83 Months 9 Days 21
If less than one day hr. min.

Due to _____
Due to _____

9. Birthplace Michigan

Other conditions _____

10. Usual occupation Retired Pharmacist

Major findings: Of operations _____

11. Industry or business X

Of autopsy _____

12. Name James H. Smythe

22. If death was due to external causes, fill in the following:

13. Birthplace Unknown

(a) Accident, suicide, or homicide (specify) _____

14. Maiden name Emline Edgitt Smythe

(b) Date of occurrence _____

15. Birthplace Unknown

(c) Where did injury occur? _____

16. (a) Informant Armour Home Records,

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

(b) Address 81st and Wornall Road, K. C., Mo.

While at work _____ Means of injury _____

17. (a) Burial (b) Date thereof 8-18-43

23. Signature Army R. Shon (M. D. or other) _____

(c) Place: burial or cremation Forest Hill Cemetery

Address _____ Date signed _____

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 8-18-43 (b) D.E. Brown

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

MOTHER FATHER

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..... *E. M. Plank*
Licensed Embalmer No..... *1848*
P. O. Address..... *K. C. 710*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3570
Registrar's No. 3570

Registration District No. 149

Primary Registration District No. 1002

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME Edward B. Smythe
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive (Year)

7. Birth date of deceased Oct 26 1904
(Month) (Day) (Year)

8. AGE: Years 43 Months Days (less than one day) min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name (City, town, or county) (State or foreign country)

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

16. (a) Informant (b) Address

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

(c) Place: burial or cremation

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

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 6
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from
that I last saw him alive on
and that death occurred on the date and hour stated above.

Immediate cause of death Acute bacterial pneumonia
hypertrophy of heart Duration

Due to
Due to

Other conditions (Include pregnancy within 3 months of death) 107

Major findings: Of operations
Of autopsy See above

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 Sherry R. Thom (M. D. or other)
Address Med Dir KCC Gen Date signed 9-7-1943

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

SUPPLEMENTAL

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