

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 3 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4935

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:
2919 Lockridge
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community unknown
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2919 Lockridge
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs. Aldie R. Smith

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

4. Sex Fe 5. Color or race Wh 6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Sidney Smith 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 23, 1864
(Month) (Day) (Year)

8. AGE: Years 78 Months 10 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation At home

11. Industry or business _____

12. Name Wm. B. Jackson
13. Birthplace Ill (City, town, or county) (State or foreign country)
14. Maiden name Ellen Bright
15. Birthplace Ill (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clem P. Whinger
(b) Address 2919 Lockridge

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-43 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Thos. E. Quirk
(b) Address 4316 Troost Ave

19. (a) 11-22-43 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 20
year 1943 hour 4 minute 30 A. M.

21. I hereby certify that I attended the deceased from November 14, 1943 to November 20, 1943
that I last saw her alive on November 19, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 5 days

Due to _____
Due to 83w

Other conditions no
(include pregnancy within 3 months of death)

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? _____

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature John L. Lapp (M. D. or other) MD
Address 11314 Professional Bldg Date signed Nov 20 1943

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

8 33 88

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.....

.....
working under my personal supervision.

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

Signed.....
John E. Jewett

Licensed Embalmer No..... *3775*

P. O. Address.....
R. O. 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.