

FILED DEC 22 1943

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:  
General Hospital #2 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11-16-43-11-30-43  
(Specify whether years, months or days)  
In this community 20 Years

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. 2338 Terrace  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME HENRIETTA SMITH  
3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married. 2 divorced Widowed  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased May 26, 1905  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
38 6 4 hr. min.

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

10. Usual occupation Unemployed

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name Emanuel Waters  
13. Birthplace Okla.  
(City, town, or county) (State or foreign country)  
14. Maiden name Carrie Dozier  
15. Birthplace Okla.  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk  
(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 12-6-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Ave.

18. (a) Signature of funeral director H. C. Jones  
(b) Address 440 State Ave. K.C.M.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 30  
year 1943 hour 8:00 minute A M.  
21. I hereby certify that I attended the deceased from November 16, 1943 to Nov. 30, 1943;  
that I last saw her alive on November 30, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Far Advanced Pulmonary Tuberculosis  
Due to \_\_\_\_\_  
Due to 13 hr

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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)  
(c) Means of injury \_\_\_\_\_  
23. Signature H. E. Brown (M. D. or other) \_\_\_\_\_  
Address Gen. Hosp #2 600 E. 22nd Date signed 11-30-43

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

243  
5-17-39  
I X35607

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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.....

*Eugene English*

Licensed Embalmer No. *41025*

P. O. Address. *440 State ave. K.C., 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.**