

V. S. No. 2  
OM-9-4-41  
Rev. 5-17-39  
I X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

33433

State File No. ....

FILED OCT 29 1944

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4217

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

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: R. C. TB Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 1 y 1 m 26 d.  
(Specify whether years, months or days) 48 yrs.

In this community: 48 yrs.

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.: 2617 Montgall  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: Margery Smith

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 19  
year 44 hour 7 15 minute P. M.

21. I hereby certify that I attended the deceased from 8-28-43 1943 to 10-19 1944  
that I last saw her alive on 10-19 1944  
and that death occurred on the date and hour stated above.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: 3 divorced

6. (b) Name of husband or wife: Charles Smith

6. (c) Age of husband or wife if alive: 20 years

7. Birth date of deceased: 4 (Month) 30 (Day) 1895 (Year)

Immediate cause of death: Pulmonary Tuberculosis

Duration: 8 y. 2 m.

8. AGE: Years 49 Months 5 Days 29  
If less than one day: 0 hr. 0 min.

Due to: 13 yr!

Other conditions: 13 yr!  
(Include pregnancy within 3 months of death)

9. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation: Housewife

PHYSICIAN

Major findings: Of operations

Of autopsy: \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name: Michael Jones

13. Birthplace: No Record (City, town, or county) (State or foreign country)

14. Maiden name: Lemona

15. Birthplace: No Record (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Henry S. Stalte

(b) Address: 2505 Prospect

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof: 10-23-44 (Month) (Day) (Year)

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? \_\_\_\_\_

(c) Place: burial or cremation: Funeral Home

18. (a) Signature of funeral director: Mrs. C. J. Guter

(b) Address: 912-920 Broadway

19. (a) 10-20-44 (Date received local registrar)

(b) D. E. Brown (Registrar's signature)

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

(f) Means of injury: \_\_\_\_\_

23. Signature: Walter J. Noon (M. D. or other)

Address: Leeds, Mo. Date signed: 10/19/44

**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: *J. H. Hinch* .....

Licensed Embalmer No. *3589* .....

P. O. Address *J. H. Hinch* .....

**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.**