

FILED OCT 29 1944

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

33434

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4229

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 No. 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10-4-44-10-17-44
 (Specify whether years, months or days) 35 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. 2642 Euclid
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME SARAH J. SMYTH

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 Widow
 6. (b) Name of husband or wife unk. 6. (c) Age of husband or wife if alive 15 years 1882
 7. Birth date of deceased (Month) May (Day) 15 (Year) 1882

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>5</u>	<u>2</u>	hr. _____ min.

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

10. Usual occupation Registered nurse

11. Industry or business _____

MOTHER FATHER

12. Name Anzia Smyth
 13. Birthplace Miss. (City, town, or county) (State or foreign country)
 14. Maiden name Jennie
 15. Birthplace Miss. (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
 (b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 10-21-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln
 18. (a) Signature of funeral director Wm. E. ...

(b) Address 1819 E. 15th K.C. Mo.

19. (a) 10-21-44 (b) N. E. Brown
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 17 year 1944 hour 4:12 minute P. M.

21. I hereby certify that I attended the deceased from October 4, 19 44 to October 17, 19 44, that I last saw h. er alive on October 17, 19 44, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration _____

Due to Cerebral Sclerosis

Due to Hypertension

Other conditions 87d.
 (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? _____

(Specify type of place) While at work? Gen. Hosp. #2 (e) Means of injury _____

23. Signature G. P. ... (M. D. or other) _____

Address Gen. Hosp. #2 600 E. 22nd Date signed 10-18-44

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

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. Shymer*.....
Licensed Embalmer No. *4383*
P. O. Address *1819 E. 15th St. Keokuk*

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.