

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 15 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 150

Primary Registration District No. 4299

Registrar's No. 135

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Leis Summit  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 207 Wilson Street  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 40 yrs (Specify whether years, months or days)

In this community 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Leis Summit  
(If outside city or town limits, write "RURAL")

(d) Street No. 207 Wilson Street  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country D

3. (a) PRINT FULL NAME Melissa Jane Smith

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20  
year 1944 hour 1:30 minute A. M.

21. I hereby certify that I attended the deceased from 10-18 to 10-20, 1944  
that I last saw her alive on 10-18-44  
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 Widowed

6. (b) Name of husband or wife Winfield S. Smith 6. (c) Age of husband or wife if alive 1851 years

7. Birth date of deceased Nov 16 - 1851  
(Month) (Day) (Year)

Immediate cause of death Chr. myocarditis

Due to Senility

Due to 93d

Other conditions (include pregnancy within 3 months of death)

8. AGE: Years 92 Months 11 Days 4 If less than one day hr. min.

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

10. Usual occupation Home

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

MOTHER FATHER { 12. Name Elzy Sanders

13. Birthplace unknown

14. Maiden name Elizabeth Sanders

15. Birthplace unknown

16. (a) Informant Mrs. Daisy G. Linch

(b) Address Leis Summit Mo

17. (a) Burial (b) Date thereof 10-22-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs Mo

18. (a) Signature of funeral director F. M. Schick

(b) Address Leis Summit Mo

19. (a) Oct 21, 1944 (b) F. M. Schick  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_

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

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) (b) Means of injury \_\_\_\_\_

Signature Charles J. Jager (M.D. or other) W.D.

Address Leis Summit Mo Date signed 10-20-44

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

NOV 24 1944

**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.B. Langsford* .....  
Licensed Embalmer No..... *3833* .....  
P. O. Address..... *100 Summit St.* .....

**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.**