

No. 2  
8-43  
7-39  
X37823

FILED FEB 6 1945

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 248

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: 2000 Norridge  
Kansas City Convalescent Home 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital 4 years  
(Specify whether  
In this community 20 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City 48  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3700 Norridge 3  
(If rural, give location) 8  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 11

3. (a) PRINT FULL NAME

Ben Smith

3. (b) If veteran, name war no 3. (c) Social Security No. 510-03-7919

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 30 1886  
(Month) (Day) (Year)

8. AGE: 56 Years 58 Months 2 Days 11  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Coaler maker

11. Industry or business Varby Corp.

12. Name William Smith

13. Birthplace England  
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth

15. Birthplace England  
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Record

(b) Address 3700 Norridge, Ice Mt

17. (a) Removal (b) Date thereof 1-18-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Verdella Mo.

18. (a) Signature of funeral director C. A. Shelton

(b) Address Kansas City, Kansas

19. (a) 1-16-45 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11  
year 1945 hour 7:05 minute AM

21. I hereby certify that I attended the deceased from 9-6-44  
\_\_\_\_\_, 19\_\_\_\_, to 1-18-45, 19\_\_\_\_;  
that I last saw him alive on 1-15-45, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Ca of Stomach

Due to \_\_\_\_\_

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 [Signature] (M. D. number) \_\_\_\_\_  
Address 3700 Norridge Date given 1-19-45

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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 *R. J. Fulmer*

Licensed Embalmer No. *2503*

P. O. Address *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.**