

No. 2  
-2-43  
17-39  
X35637

FILED JAN 26 1945  
199

Registration District No.

Primary Registration District No. 1002

Registrar's No. 265

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: K. C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether years, months or days)

In this community 28 years

3. (a) PRINT FULL NAME Lee Smith

3. (b) If veteran, name war no

3. (c) Social Security No. 489-24-3934

4. Sex M Color of race W

5. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mrs Leticia E Smith

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Aug 24 1877  
(Month) (Day) (Year)

8. AGE: Years 67 Months 4 Days 23 If less than one day 27 hr. min.

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

10. Usual occupation Painting Contractor

11. Industry or business

12. Name Charles Smith

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

14. Maiden name Unknown

15. Birthplace St. Wayne Ind  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Leticia E. Smith

(b) Address 4214 Euclid Ave

17. (a) Burial (b) Date thereof Jan 18-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director W. H. Newman Sons

(b) Address 1401 Bush Creek

19. (a) 1-17-45 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

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. 4214 Euclid  
(If rural, give location)

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

If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 16 year 1945 hour 10 minute 10 A. M.

21. I hereby certify that I attended the deceased from Jan. 9 1945 to Jan. 16 1945 that I last saw him alive on Jan. 16 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia  
Malnutrition

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

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

Other conditions 107  
(Include pregnancy within 3 months of death)

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

Of autopsy None

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)

(a) Means of injury \_\_\_\_\_

23. Signature A. E. Osener (M. D. or other) no

Address Med. Dir. Gen'l Hosp. Date signed \_\_\_\_\_

361

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

JAN 26 1945

---

---

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..... *Frank Newcomer* .....

Licensed Embalmer No... *1028* .....

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 265

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

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town N. C.  
(c) Name of hospital or institution:  
Gen. Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAMES See Rufus Smith

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased. (Month) (Day) (Year)

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

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

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof. (Month) (Day) (Year)

(Burial, cremation, or removal) \_\_\_\_\_

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 1-17-45 (b) P. E. Brown (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Jan. day 16 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_ that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

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

Due to Broncho pneumonia

Due to malnutrition

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) (e) Means of injury \_\_\_\_\_

23. Signature A. E. Upsher (M. D. or other) \_\_\_\_\_

Address Gen. Hosp. Date signed 1-17-45

SUPPLEMENTARY

1444