

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF THE CENSUS  
**FILED JUL 17 1945 STANDARD CERTIFICATE OF DEATH**

23221

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

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2852

1. PLACE OF DEATH:  
 Jackson  
 (a) County \_\_\_\_\_  
 (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 0  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6-27-45-7-5-45  
(Specify whether  
 In this community unknown  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 Missouri Jackson 48  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1521 Central 8  
(If rural, give location)  
 (e) Citizen of foreign country? unknown (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Frank Smith  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 5  
 year 1945 hour 9 minute 30 P. M.

4. Sex Male 5. Color of race W  
 6. (a) Single, widowed, married, divorced unk  
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased unknown  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 27 1945 to July 5 1945  
 that I last saw him alive on July 5 1945  
 and that death occurred on the date and hour stated above.

8. AGE: Years 61 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

Immediate cause of death \_\_\_\_\_  
Pulmonary tuberculosis

10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 MOTHER FATHER { 12. Name unknown  
 13. Birthplace \_\_\_\_\_ 9  
(City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_ 9  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

16. (a) Informant W. M. Wellett  
 (b) Address 215 21 Central  
 17. (a) burial (b) Date thereof 7-6-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Kentersville Mo

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

18. (a) Signature of funeral director Geraldine Helmer  
 (b) Address 1521 Central  
 19. (a) 7-7-45 (b) Geraldine Helmer  
(Date received local registrar) (Registrar's signature)

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 Clark W. Sealy MD (M. D. or other)  
 Address Med. Dir. K. General Hospital Date signed \_\_\_\_\_

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

*John B. Reynolds*

Licensed Embalmer No. *04273*

P. O. Address *KCMO*

**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.**