

**FILED FEB 7 1946**

Registration District No. \_\_\_\_\_

Primary Registration District No. **1002**

Registrar's No. **421**

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Kansas City**  
(c) Name of hospital or institution:  
**1119 Oakview Avenue**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community **94 years** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(d) Street No. **1119 Oakview Avenue**  
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME

**Edwin Fairfield Smith**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **none**

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Elizabeth Smith**

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

7. Birth date of deceased **September 3 1861**

8. AGE:	Years	Months	Days	If less than one day
	<b>84</b>	<b>4</b>	<b>21</b>	hr. _____ min. _____

9. Birthplace **Racine Wisconsin**

10. Usual occupation **Retired 9 years**

11. Industry or business **Farmer**

12. Name **Edwin Fairfield Smith**

13. Birthplace **unknown**

14. Maiden name **Mary unknown**

15. Birthplace **unknown**

16. (a) Informant **William F. Smith**

(b) Address **1119 Oakview Avenue**

17. (a) **REMOVAL** (b) Date thereof **JAN. 25, 1946**

(c) Place: burial or cremation **BAYARD IOWA**

18. (a) Signature of funeral director **J. H. Newcomer**

(b) Address **1401 S. Main Street, Blvd.**

19. (a) **1-25-46** (b) **Seraldine Holmes**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **24th**  
year **1946** hour **3** minute **40** -M.

21. I hereby certify that I attended the deceased from **Jan 15 1946** to **Jan 24 1946**  
that I last saw him alive on **Jan 23 1946**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Congestive Heart Failure** Duration **24 hrs**

Due to **Influenza & Old Age**

Other conditions \_\_\_\_\_

Major findings: **36**

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 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(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 **W. H. Newcomer** (M. D. or other) \_\_\_\_\_

Address **Springfield Mo** Date signed **1/24/46**

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

125A

Parkville, Mo.

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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 Emile M. Calhoun  
Licensed Embalmer No. 3506  
P. O. Address K C Mo

**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.**