

**FILED** MAR 18 1946

Registration District No. 149

Primary Registration District No. 1002

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:  
3541 Genessee /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 3yr.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson #8  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3541 Genessee 8  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sandra Elizabeth Smith

3. (b) If veteran, name war \_\_\_\_\_ no  
3. (c) Social Security No. none

4. Sex Fe / 5. Color or race White  
6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 600 years

7. Birth date of deceased 6 12 1942  
(Month) (Day) (Year)

8. AGE: Years 3 Months 8 Days 26  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kansas City Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation school

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

12. Name John Smith 0

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

14. Maiden name Claradine Ely

15. Birthplace Kansas City Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant John Smith

(b) Address 3541 Genessee

17. (a) Burial (b) Date thereof 3-11-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director [Signature]

(b) Address 411 1/2 + State Line Bldg

19. (a) 3-9-46 (b) Seraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8  
year 1946 hour [6:15/12] minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Jan 16  
1946, to March 8 1946;  
that I last saw her alive on March 7 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Lymphatic Leukemia Duration 3 months?

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

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

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

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

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

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 0

23. Signature [Signature] (Nurse or other) \_\_\_\_\_

Address 2426 Play Medical Bldg Date signed 3/6/46

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

MOTHER FATHER

8615

**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..... *Wm J Ward* .....  
Licensed Embalmer No..... *3991* .....  
P. O. Address..... *309 E 67th* .....

**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.**

*K.P.M.*