

No. 2  
-5-43  
-17-39  
X36671

FILED SEP 3 1946

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

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3626

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: Research Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days (Specify whether  
as above (Specify whether  
in this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Mrs. Lydia Caroline Smith

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

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

6. (b) Name of husband or wife Algernon R. Smith 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased April 21 1885  
(Month) (Day) (Year)

8. AGE: Years 61 Months 3 Days 27 If less than one day 26 hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Music Teacher

11. Industry or business Music

12. Name Charles Schafermeyer

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

14. Maiden name Justine Kriehn

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

16. (a) Informant Algernon R. Smith

(b) Address 1614 Franklin Ave., Lexington, Mo.

17. (a) removal (b) Date thereof 8-17-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington, Missouri

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 8-21-46 (b) Theraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 54  
(c) City or town Lexington 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. x 1614 Franklin 2  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No) 1  
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17th  
year 1946 hour 4:00 minute \_\_\_\_\_ P. \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from Aug 13, 1946, to Aug 17, 1946  
that I last saw h. ll alive on Aug 17, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Gastric Hemorrhage.  
Due to Tumor of Stomach

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

Major findings \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy Tumor of Stomach  
C. Ulceration

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 E. H. Wilkinson (M. D. or dentist) M.D.  
Address 1103 Frank Ave Date signed 8/20/46

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

OCT 1 1946

*Carroll B. [unclear]*  
*R.M. [unclear]*

Dr. J. G. Montgomery

**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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address N.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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3626

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: Research 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.)

3. (a) PRINT FULL NAME Sydia Caroline 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 \_\_\_\_\_ years

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 { 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 \_\_\_\_\_ (Month) (Day) (Year)

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

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

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

19. (a) 8-21-46 (b) Heraldine Holmes (Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17 year 1946 hour 4 minute 00 P.M.

21. I hereby certify that I attended the deceased from Aug 13 1946 to 8-17 1946 that I last saw her alive on 8-17 1946 and that death occurred on the date and hour stated above.

Immediate cause of death gastric hemorrhage  
Due to tumor of stomach - benign

Other conditions none  
(include pregnancy within 3 months of death)

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

Of autopsy tumor of stomach & ulcerated

22. If death was due to external cause, fill in the following:  
(a) Accidents, 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 E. A. Wilkinson (M. D. or other) \_\_\_\_\_  
Address 1103 Grand Date signed 8-20-46

SUPPLEMENTAL

PHYSICIAN

Underline the cause to which death should be charged statistically.

26  
System of information should be carefully supplied. AGI should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

1. PLACE OF DEATH:

(a) County.....  
 (b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 .....  
(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)

3. (a) PRINT FULL NAME

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..... years

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.....

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.....  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a)..... (b).....  
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country?..... (Yes or No)  
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....  
 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....  
 Due to.....  
 Due to.....  
 Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
 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.....  
 (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..... (M. D. or other).....

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

FATHER {  
MOTHER {

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.