

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 24 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13797
State File No. _____
Registrar's No. 61

Registration District No. 150 Primary Registration District No. 5573

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Grain Valley
(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 50 yrs years, months or days

3. (a) PRINT FULL NAME Albert a Smith
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Agnes 6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased May 8 1869
(Month) (Day) (Year)

8. AGE: Years 80 Months 11 Days 1 If less than one day hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Abraham Smith

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

14. Maiden name Elizabeth McLean

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

16. (a) Informant Mrs Agnes Smith
(b) Address Grain Valley mo

17. (a) Buried (b) Date thereof 4-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blue Springs mo
18. (a) Signature of funeral director Mrs G B Webb, Son
(b) Address Blue Springs mo
19. (a) Apr 12, 1947 (b) Albert C. Pennington
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town Grain Valley (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9
year 47 hour 5 minute P M.
21. I hereby certify that I attended the deceased from March 30
1947, to April 9 1947
that I last saw him alive on April 9 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure Duration _____

Due to Dehydration 11 days

Due to Influenza & diarrhea 6 weeks
produced by over-dose of laxatives

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 _____

23. Signature M A Bay (M. D. or other)
Address Blue Springs mo Date signed 4-10-47

APR 25 1997

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.....

Francis J. Schabug

....., Registered Apprentice No. *464*

working under my personal supervision.

Signed..... *R. B. [Signature]*

Licensed Embalmer No. *2353*

P. O. Address *Blue Spring Md*

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.