

National Office of Vital Statistics

State File No. 4446

FILED NOV 4 1947

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 4446

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 General Hospital No. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day 16 hrs.
 (Specify whether years, months or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 3
 (If outside city or town limits, write "RURAL")
2803 Spruce 8
 (d) Street No. (If rural, give location) 0
 (e) Citizen of foreign country? no. (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME

William A. Smith
 3. (b) If veteran name war None 3. (c) Social Security No. none

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Lizzie M. Smith 6. (c) Age of husband or wife if alive 70 years
 7. Birth date of deceased April 11 1876
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 06 11 hr. min.

9. Birthplace Jackson Co., Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Night Watchman
City Market

11. Industry or business Smith

12. Name no record 9

13. Birthplace no record (City, town, or county) (State or foreign country)

14. Maiden name no record

15. Birthplace no record (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lizzie M. Smith
 (b) Address 2803 Spruce

17. (a) Burial (b) Date thereof Oct. 25, 47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Mrs. C. L. Forster
 (b) Address 918 Brooklyn

19. (a) 10-24-47 (b) Theraldine Holmes
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 22
 year 1947 hour 11 minute 20 P. M.

21. I hereby certify that I attended the deceased from Oct. 21, 1947, to Oct. 22, 1947,
 that I last saw him alive on Oct. 22, 1947,
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Aneurysm of descending
aorta with rupture into
post mediastinum

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings:.....

Of operations:.....

Of autopsy: See above

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? (Specify type of place).....

While at work? (e) Means of injury.....

23. Signature Wm W. [unclear] (M. D. or other) MD

Address Med. Dir. Gen'l Hosp. Date signed 10-23-47

Address.....

Address.....

Address.....

Dr. Hubert P

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 *Dean Owens*

Licensed Embalmer No. *4280*

P. O. Address *918 B Brooklyn*
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.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4446

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:
(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 William A. 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 _____

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) 10-24-47 (b) M. A. 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 October 1947
 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.
 Immediate cause of death _____

aneurysm of descending aorta with rupture into post-mediastinum (h.s.)
 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 _____

23. Signature Wm. W. Hart (M. D. or other) _____

Address Gen. Hosp. #1 Date signed _____

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

SUPPLEMENTARY

S-34681