

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **12889**
1863
Registrar's No. **1863**

Registration District No. **149**

Primary Registration District No. **1002**

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

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 #2 0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **14 days**
(Specify whether years, months or days) **50 yrs.**

3. (a) PRINT FULL NAME **ARTHUR A SMITH**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **no**

4. Sex **MALE** 5. Color or race **NEGRO** 6. (a) Single, widowed, married, divorced **WIDOWER**

6. (b) Name of husband or wife **Unknown** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **JANUARY 1 1877**
(Month) (Day) (Year)

8. AGE: Years **71** Months **3** Days **26** If less than one day hr. min.

9. Birthplace **SEDALIA MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **LABORER**

11. Industry or business

12. Name **LOUIS SMITH**

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

14. Maiden name **GEORGIA MANTEN**

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

16. (a) Informant **SELF (Deceased)**

(b) Address **K.C. Mo.**

17. (a) **Burial** (b) Date thereof **4/30/1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Funerals Mo**

18. (a) Signature of funeral director **F. D. Ferguson**

(b) Address **Sedalia Mo.**

19. (a) **4-28-48** (b) **Theraldine Holmes**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON**
(c) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL")
(d) Street No. **912 East 16th Street**
(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 **127**
year **1948** hour **6:20** minute **P.** m.

21. I hereby certify that I attended the deceased from **APRIL 13**, 19 **48**, to **April 27**, 19 **48**
that I last saw him alive on **April 27**, 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **PERFORATED PEPTIC ULCER (malignancy undetermined) Probably Malignant**

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

Major findings: Of operations **4/6/48**
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) (c) Means of injury **MMO**
23. Signature **Theraldine Holmes** (M. D. or other)
Address **600 East 22nd St.** Date signed **4/28/48**

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.