

FILED APR 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12683

BIRTH NO. _____		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 1454	
1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 40 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City			
d. FULL NAME OF HOSPITAL OR INSTITUTION 2835 Belleview				d. STREET ADDRESS (If rural, give location) 2845 Belleview			
3. NAME OF DECEASED (Type or Print) a. (First) ARCHIE		b. (Middle) C.		c. (Last) SMITH		4. DATE OF DEATH (Month) (Day) (Year) March 29 1949	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED married		8. DATE OF BIRTH Aug. 24, 1906	
9. AGE (In years last birthday) 42		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Mins.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) welder		10b. KIND OF BUSINESS OR INDUSTRY Luthey Bros.		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME ARTHUR SMITH		13b. MOTHER'S MAIDEN NAME NELLIE HALLESSEY		14. NAME OF HUSBAND OR WIFE CATHERINE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 496-03-7220		17. INFORMANT'S SIGNATURE OR NAME Catherine M. Smith		ADDRESS 2845 Belleview	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) coronary Sclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Deputy Coroner				20. AUTOPSY? YES ☒ NO ☐	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE A. E. Updegraff M.D. (Degree or title)		23b. ADDRESS 2800 Main		23c. DATE SIGNED 3/30/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 4/2/49		24c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery		24d. LOCATION (City, town, or county) (State) Stanley, Kansas	
DATE REC'D BY LOCAL REG 3-31-49		REGISTRAR'S SIGNATURE Seraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Quirk & John		ADDRESS 20 West Linwood	

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Maudie Adair

Signed _____
Student Embalmer

Licensed Embalmer No. *4016*

P. O. Address *20 W. Linwood*

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.