

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43336**  
Registrar's No. **228**

FILED JAN 5 1954

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <b>150</b>   |  | PRIMARY REG. DIST. NO. <b>5574</b>  |  | Registrar's No. <b>228</b>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <b>Grain Valley (Rural)</b>   |  | c. LENGTH OF STAY (in this place) <b>3 yrs</b>  |  | c. CITY OR TOWN <b>Grain Valley</b>   |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>10 Mi South (Van Buran Twp)</b>   |  |   |  | e. STREET ADDRESS (If rural, give location) <b>10 Mi South Van Buran Twp</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Fred</b>  |  | b. (Middle) <b>L</b>  |  | c. (Last) <b>Smith</b>  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Dec 12 1953</b>   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>W</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>   |  | 8. DATE OF BIRTH <b>Jan 11 1874</b>   |  |
| 9. AGE (In years last birthday) <b>79</b>  |  | IF UNDER 1 YEAR Months _____ Days _____   |  | IF UNDER 4 HRS. Hours _____ Min. _____  |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Blue Springs Mo</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>O.A.P.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>   |  |   |  |
| 13a. FATHER'S NAME <b>Frank Smith</b>  |  | 13b. MOTHER'S MAIDEN NAME <b>Sarah Montgomery</b>   |  | 14. NAME OF HUSBAND OR WIFE <b>Deceased</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>***-**-****</b>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Hubert Smith Blue Springs Mo</b>   |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>   |  |
| 19a. DATE OF OPERATION _____   |  | 19b. MAJOR FINDINGS OF OPERATION _____  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 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) <b>4201</b>   |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21f. HOW DID INJURY OCCUR? _____  |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>12-12, 1953</b> , to <b>12-12, 1953</b> , that I last saw the deceased alive on <b>12-12, 1953</b> , and that death occurred at <b>11:00 Am.</b> , from the causes and on the date stated above. |  |   |  |   |  |   |  |
| 23a. SIGNATURE (Degree or title) <b>Clint Miller MD</b>  |  |   |  | 23b. ADDRESS <b>Lees Summit Mo</b>  |  | 23c. DATE SIGNED <b>12-13-53</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24b. DATE <b>Dec 14-53</b>  |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Blue Springs</b>  |  | 24d. LOCATION (City, town, or county) (State) <b>Blue Springs Mo MO</b>   |  |
| DATE REC'D BY LOCAL REG. <b>12-16-53</b>   |  | REGISTRAR'S SIGNATURE <b>N. B. Langford</b>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Webb Funeral Home Blue Springs Mo</b>   |  |   |  |

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

Rawlett

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..

Student.....  
Signature of Student Embalmer

Signed..... *R B Webb*

Licensed Embalmer No. *2353*

P. O. Address *Blue Springs*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.