

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20835**

FILED JUN 27 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **3026** Registrar's No. **282**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Independence</b>		c. LENGTH OF STAY (in this place) <b>2</b>	c. CITY OR TOWN <b>Kansas City</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sanitarium</b>		e. STREET ADDRESS (If rural, give location) <b>226 N. Cedar</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Thomas</b>	b. (Middle) <b>LeRoy</b>	c. (Last) <b>Smith</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 20, 1956</b>
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Oct. 28, 1914</b>	9. AGE (in years last birthday) <b>41</b>	IF UNDER 1 YEAR Months <b>4</b>	IF UNDER 1 YEAR Days <b>1</b>	IF UNDER 1 YEAR Hours <b>1</b>	IF UNDER 1 YEAR Min. <b>1</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stillman helper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Standard Oil Co.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Sedalia, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Robt. S. Smith</b>	13b. MOTHER'S MAIDEN NAME <b>Daisey M. Mann</b>	14. NAME OF HUSBAND OR WIFE <b>Ruby F. Smith</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>487 05 3950</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Ruby F. Smith, Kansas City, Mo.</b>	ADDRESS <b>Kansas City, Mo.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>3 weeks</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute Streptococcal Meningitis</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <b>Ruptured Brain abscess</b>		
DUE TO (b)		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	<b>3402</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **May 26, 1956** to **June 20, 1956**, that I last saw the deceased alive on **June 20, 1956**, and that death occurred at **10:25 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Fred W. Link, M.D.</b>	(Degree or title)	23b. ADDRESS <b>10229 Wedg., K.C. Mo.</b>	23c. DATE SIGNED <b>6/21/56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>6/23/56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington Cem</b>	24d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>6-23 56</b>	REGISTRAR'S SIGNATURE <b>James Craig</b>	25 FUNERAL DIRECTOR'S SIGNATURE <b>G. C. Carson</b>	ADDRESS <b>Independence, Mo.</b>
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(License Embalmer's Statement on Reverse Side)

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

354

1961 & 8 NRP

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 Tom D. Markland

Licensed Embalmer No. 459

P. O. Address Indep

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.