

Health,
Welfare
Public
Service

300
1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 24 1956

34247

STATE FILE NUMBER

4245

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Gen'l Hosp. #1</u>		Length of stay in lb <u>35 yrs.</u>	STREET ADDRESS <u>16th STREET 1213$\frac{1}{2}$ Troost</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>A.</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>3</u> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Jul 26 1898</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Urbana Kansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Alva Smith</u>			14. MOTHER'S MAIDEN NAME <u>Amanda Foster</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) <u>Yes World War No 2.</u>		16. SOCIAL SECURITY NO. <u>195-05-5230</u>		17. INFORMANT <u>Juanita Robinette Kansas City, Missouri</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Acute hepatitis.</u>					
DUE TO (c) <u>Homologus serum jaundice (m.m.c.)</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <u>Sept. 24, 1956</u> to <u>Sept. 27, 1956</u> and last saw him <u>him</u> alive on <u>Sept. 27, 1956</u> ✓ Death occurred at <u>9:20 A.</u> _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>B. I. Burns, M.D.</u> (Degree or title) <u>B. I. Burns</u>			22b. ADDRESS <u>24th & Cherry</u>		22c. DATE SIGNED <u>9-28-56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<u>Burial</u>		<u>Sep. 29 1956</u>	<u>Maple Hill Cem.</u>		<u>Kansas City, Kansas</u>
24. FUNERAL DIRECTOR <u>Mrs C.L. Forster Funeral Home K.C. Mo.</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>9-29-56</u>		26. REGISTRAR'S SIGNATURE <u>Max. Minshall</u>

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was examined
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 35

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.