

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32178
STATE FILE NUMBER
3933
Registrar's No.

FILED SEP 19 1957

Registration District No. 149 Primary Registration District No. 1002

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, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1604 Montgall		d. STREET ADDRESS 1604 Montgall	
3. NAME OF DECEASED (Type or print) First MARY Middle SMITH Last SMITH		4. DATE OF DEATH Month August Day 20 Year 1957	
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Dalton		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE James H. Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mamie Manier		Address 1632 1/2 E. 18th St. Niece	
18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility Cerebral Hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) unknown DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 331+
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 8-18-57 to 8-19-57 and last saw her alive on 8-19-57 , Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE F. J. Haugh, Sr. (Degree or title)		22b. ADDRESS 2200 East 18th St.	
22c. DATE SIGNED 8-24-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-29-57	23c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn
23d. LOCATION (City, town, or county) Kans. City, Missouri		(State)	
24. FUNERAL DIRECTOR Ernest Jones		ADDRESS 18th St. Park	25. DATE RECD. BY LOCAL REG. 8-21-57
26. REGISTRAR'S SIGNATURE Neva Minshall			

MEDICAL CERTIFICATION
F. J. Haugh, Sr. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.



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 *Bruce P. Watkins*.....

Licensed Embalmer No. *4574*.....

P. O. Address *187th & Benton*

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.