

FILED JAN 8 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44603  
STATE FILE NUMBER  
6044

Registration District No. 149 Primary Registration District No. 1.002 Registrar's No.

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, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Trinity Lutheran Hosp.</b>		Length of stay in lb <b>30 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>8119 MAIN STREET</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gus Jay Smith</b>			4. DATE OF DEATH Month Day Year <b>DEC. -18 1957</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1886</b>		9. AGE (In years last birthday) <b>71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-AYAS-EMPLOYEE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AMERICAN OPTICAL CO.</b>	11. BIRTHPLACE (City and state or country) <b>HENRY COUNTY, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>E. H. SMITH</b>		13b. MOTHER'S MAIDEN NAME <b>ALLIE QUICK</b>		14. NAME OF HUSBAND OR WIFE <b>MRS. EFFIE D. SMITH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>493-14-8398</b>	17. INFORMANT Address <b>MRS. MAXINE EDWARDS 8119 MAIN STREET KANSAS CITY, MO.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b>					INTERVAL BETWEEN ONSET AND DEATH <b>only 1 mo.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					157+
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>diabetes mellitus</b>					
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, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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: <b>8-30-57</b> to <b>12-18-57</b> and last saw <sup>him</sup> alive on <b>12-18-57</b> Death occurred at <b>5:57 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Wilson H. Miller M.D.</b>			22b. ADDRESS <b>4620 Indeg. Ave Kansas City Mo</b>		22c. DATE SIGNED <b>12-19-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>DEC. 20-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAH CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>	
24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons</b>		ADDRESS <b>381 BRUSH CREEK R.C. MO.</b>	25. DATE RECD. BY LOCAL REG. <b>12-20-57</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshull</b>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

WILSON H. MILLER USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION



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 *Ed Nelson* .....

Licensed Embalmer No. *24401* .....

P. O. Address *Kansas City, Mo* .....

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.