

Health,
Welfare
Public
Service

300
-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005855
STATE FILE NUMBER
591

FILED FEB 24 1958

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

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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4422 Paseo		Length of stay in lb 57 Yrs.	d. STREET ADDRESS (If outside, give location) 4422 Paseo		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Claude Middle O. Last Smith			4. DATE OF DEATH Month 2 - Day 2 - Year 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1900	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (City and state or country) Braymer, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Wm. Smith		13b. MOTHER'S MAIDEN NAME Julia Sams		14. NAME OF HUSBAND OR WIFE Juanita 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. 186-36-1927		17. INFORMANT Address Mrs. Juanita Smith 4422 Paseo K.C. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Coronary arteriosclerosis DUE TO (c) Coronary artery insufficiency - Angina Pectoris - 2+ years					INTERVAL BETWEEN ONSET AND DEATH 2 hours 3+ years 4201
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 _____ a.m. _____ p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
20e. CITY, TOWN, OR LOCATION 6-29-55 to 3-18-57 and last saw him alive on 3-18-57		20f. COUNTY		20g. STATE	
21. I attended the deceased from Death occurred at 11:00 AM. 2-2-58		22a. SIGNATURE (Degree or title) Carl R. Ferris M.D.		22b. ADDRESS 535 Angyle Bldg Kansas City, Missouri	
22c. DATE SIGNED 2-3-58		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-4-58	
23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery		23d. LOCATION (City, town, or county) Kansas City		23e. STATE Missouri	
24. FUNERAL DIRECTOR Melody-McGilley-Lylar 1800 Linwood		25. DATE RECD. BY LOCAL REG. 2-4-58		26. REGISTRAR'S SIGNATURE neva minshall	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Carl R. Ferris

Carl R
D. F. F. F.
Clyde Reed
No 2-822

1-5PM

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 *James E. Hackleman*

Licensed Embalmer No. *4573*
P. O. Address *J. C. Moore*

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.