

Health, Welfare
Public
Service

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010199
STATE FILE NUMBER
1173

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1173

300
-57

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 DECEASED (If NOT a hospital, give location) HOSPITAL OR INSTITUTION <u>Osteopathic Hosp 11th & Harrison</u>		Length of stay in lb <u>Life Span</u>	d. STREET ADDRESS (If outside, give location) <u>315 W. 9th.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Arthur</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>58</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-85</u>	9. AGE (In years last birthday) <u>72</u>	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Inns Company</u>	11. BIRTHPLACE (City and state or country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert N. Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Shaw</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>487-12-5729</u>	17. INFORMANT Address <u>Mrs. Lottie Wanbaugh (Sister)</u>			
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>BRONCHOPNEUMONIA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>PULMONARY Edema due to myocardial unknown decompensation +</u>	DUE TO (c) <u>Generalized Arteriosclerosis unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>H221</u>					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 <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u>					
20d. INJURY OCCURRED WHILE AT <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>Feb 10 1958</u> to <u>MAR 1, 1958</u> and last saw ^{him} alive on <u>March 1, 1958</u> Death occurred at <u>6:45 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Verner J. Ames</u> (Degree or title) <u>2</u>		22b. ADDRESS <u>926 E. 11th St. K.C., Mo</u>		22c. DATE SIGNED <u>3-4-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3-3-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>		
24. FUNERAL DIRECTOR <u>Simmons Funeral Home</u> ADDRESS <u>K.C.K.</u>		25. DATE RECD. BY LOCAL REG. <u>3-4-58</u>	26. REGISTRAR'S SIGNATURE <u>Gene Minshall</u>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Donovan K. James*

Licensed Embalmer No. *4828*

P. O. Address *K.C.K.*

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.