

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010201
STATE FILE NUMBER
1277

FILED MAR 31 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1277

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-57
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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>Curits Nursing</u>		Length of stay in lb <u>Most of t</u> Life	d. STREET ADDRESS <u>3507 Paseo</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Margaret Catherin Smith</u>			4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1958</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/9/1874</u>
9. AGE (In years last birthday) <u>83</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Marshall, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13a. FATHER'S NAME <u>James Flynn</u>	
13b. MOTHER'S MAIDEN NAME <u>Bridgett Corrigan</u>		14. NAME OF HUSBAND OR WIFE <u>Finns G. Smith</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>None</u>	17. INFORMANT <u>Maume S. Tuttle</u> Address <u>3507 Paseo</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>Cardiovascular accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>one day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic heart disease</u>			<u>unknown</u>
DUE TO (c) <u> </u>			<u>4-20</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 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 <u> </u> STATE <u> </u>	
21. I attended the deceased from <u>7 Mar. '58</u> to <u>8 Mar. '58</u> and last saw her alive on <u>8 Mar. '58</u> Death occurred at <u>3:00</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>William R. Roberts, M.D.</u> (Degree or title) <u>0</u>		22b. ADDRESS <u>12921 Grandview Rd.</u>	22c. DATE SIGNED <u>10 Mar. '58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/11/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Moriah Cemetery</u>	23d. LOCATION (City, town, or county) <u>Kansas City Missouri</u> (State)
24. FUNERAL DIRECTOR <u>Gates Funeral Home Kan</u> ADDRESS <u>City Kan</u>		25. DATE RECD. BY LOCAL REG. <u>3-10-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>

William R. Roberts USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

12973 Standard Pl.



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 *Paul R. Williams*

Licensed Embalmer No. *5009*

P. O. Address *Overland*

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.