

THE DIVISION OF HEALTH OF MISSOURI 64973-58  
**STANDARD CERTIFICATE OF DEATH**

58-029265  
 STATE FILE NUMBER

Health,  
 & Welfare  
 Public  
 Service

300  
 1-57

FILED SEP 5 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3976

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</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>Trinity Lutheran Hosp 13th</u> Length of stay in lb. <u>13</u>		d. STREET ADDRESS (If outside, give location) <u>337 Brooklyn</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GERALD JOSEPH SMITH</u>			4. DATE OF DEATH Month Day Year <u>8-16-1958</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>8-16-1958</u>
9a. AGE (In <sup>Yrs</sup> last birthday) <u>13</u>		9b. F UNDER 1 YEAR Months Days Hours Min. <u>13</u>	9c. IF UNDER 24 HRS. <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Emerson S. Smith</u>	
13b. MOTHER'S M maiden name <u>Josephine Sarone</u>		14. NAME OF HUSBAND OR WIFE <u>---</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give nature and dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Emerson S. Smith</u> Address <u>337 Brooklyn</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>Congenital Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>---</u> DUE TO (c) <u>---</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>7 1/2</u>
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.) <u>---</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>---</u>			
20d. INJURY OCCURRED WHILE AT WORK <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.) <u>---</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>---</u>
21. I attended the deceased from <u>8-16-58</u> to <u>8-16-58</u> and last saw <sup>her</sup> him alive on <u>8-16-58</u> Death occurred at <u>8-16-58</u> <u>3:55</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Occupation or title) <u>Otto W. Theel M.D.</u>		22b. ADDRESS <u>4301 Main St.</u>	22c. DATE SIGNED <u>8-18-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>8-18-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Mary Cem</u>	23d. LOCATION (City, town, or County) (State) <u>Kansas City, Mo.</u>
24. FUNERAL DIRECTOR <u>Kassiano Bud KC Mo.</u> ADDRESS <u>---</u>		25. DATE RECD. BY LOCAL REG. <u>8-18-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Otto W. Theel

Dr. V. Hill  
4301 Adams

WR 13194

Cen. 2 9302

WR 19500

Hospital No. 1-8351 1030 AM



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 *Leonard S. Sauerbrey* .....

Licensed Embalmer No. *4554* .....

P. O. Address *KC 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.