

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017949

FILED JUN 9 1959

Registration District No. 149

Primary Registration District No. 1002

STATE FILE NUMBER 2076  
Registrar's No.

300  
-57

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) 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 5119 OLIVE STREET		Length of stay in 1b 44 YEARS	d. STREET ADDRESS (If outside, give location) 5119 OLIVE STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last AGNES DONA SMITH			4. DATE OF DEATH Month Day Year APRIL 24, 1959
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 20, 1872
9. AGE (In years last birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (City and state or country) TEXAS COUNTY, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME ROBERT STUBBS	13b. MOTHER'S MAIDEN NAME AGNES LANE
14. NAME OF HUSBAND OR WIFE MAYHUE 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. NONE
17. INFORMANT MRS. ALTA MAE KIRIAKOS-KANSAS CITY, MISSOURI		Address 5119 OLIVE ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Cerebral Hemorrhage</i> DUE TO (c) <i>Hypertension + senility</i>			INTERVAL BETWEEN ONSET AND DEATH 24 hrs. April 16 1959 Dec 7 1956
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Nause</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <i>Dec 7 1956</i> to <i>April 23 1959</i> and last saw her alive on <i>April 23 1959</i> Death occurred at <i>2:50 A.M.</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS <i>3100 Transit Kansas City 9 Mo 4/24/59</i>	22c. DATE SIGNED <i>4/24/59</i>
23a. BURIAL CREMATION, (Specify) SERIAL	23b. DATE <i>4/26/1959</i>	23c. NAME OF CEMETERY OR CREMATORY MASONIC CEMETERY	23d. LOCATION (City, town, or county) (State) CAMDEN POINT, MISSOURI
24. FUNERAL DIRECTOR 1381 BRUSH CREEK BLVD. D. W. NEWCOMER'S SONS-KANSAS CITY, MO.		25. DATE RECD. BY LOCAL REG. <i>4, 25, 59</i>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

J. S. Van Wye USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



after 11:30 p.m.

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 W. Pearson* .....

Licensed Embalmer No. *3889* .....  
P. O. Address *A.C. 7/0* .....

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.