I DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

59-029320
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3939

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
Length of stay in 1b: 48 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 4010 Olive
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4010 Olive
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: CHARLES Middle: IRWIN Last: SMITH

4. DATE OF DEATH: Month: 8 Day: 13 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: Aug 6 1911

9. AGE (last birthday): 48

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HR: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bricklayer

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (City and state or country): Kansas City, Mo

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Charles N. Smith

13b. MOTHER'S MAIDEN NAME: Rosette Norden

14. NAME OF HUSBAND OR WIFE: Margaret A. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 487-05-9992

17. INFORMANT: Margaret A. Smith Address: 4010 Olive 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): Myocardial degeneration

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Chronic Nephritis

DUE TO (c): Cirrhosis of liver.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 May 14-1959 to Aug 13-1959 and last saw her/him alive on Aug-12-1959
Death occurred at 1:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE G C Remley (Degree or title) MD

22b. ADDRESS 936 Argyle Bldg

22c. DATE SIGNED 8-13-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 8/15/1959

23c. NAME OF CEMETERY OR CREMATORY: Floral Hills Cemetery

23d. LOCATION (City, town, or county) (State): K.C. Mo

24. FUNERAL DIRECTOR ADDRESS: C. H. Blackmon & Son Inc

25. DATE RECD. BY LOCAL REG.: 8.13.59

26. REGISTRAR'S SIGNATURE: Irene Marshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF G. C. Remley

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Bert B. Ben

Signature of Student Embalmer

Licensed Embalmer No. 465

P. O. Address K. C.,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.