

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-001894

FILED VS. FEB. 4 1960 149

497

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>30 Yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4437 Jefferson</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>ALBERT</b> Last <b>SMITH</b>			4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-19-1899</b>	9. AGE (last birthday) <b>60</b>	
				IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner &amp; Driver J. A. Smith Trucking Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co.</b>		11. BIRTHPLACE (City and state or country) <b>Hatfield, Mo.</b>		
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>Reynold Smith</b>	13b. MOTHER'S MAIDEN NAME <b>Idia Frances Koger</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Louise Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>495-07-7805</b>	17. INFORMANT <b>Mrs. Louise Smith, Kansas City, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)						
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year					
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 <b>1-24-60</b> to <b>1-26-60</b> and last saw him alive on <b>1-25-60</b> . Death occurred at <b>3:10 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>A W Robinson MD</b> (Degree or title)			22b. ADDRESS <b>4635 Hazelton Ave</b>		22c. DATE SIGNED <b>1-26-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-30-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Moriah Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>			
24. FUNERAL DIRECTOR <b>FREEMAN MORTUARY, Kansas City, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>1-27-60</b>	26. REGISTRAR'S SIGNATURE <b>neva munnell</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

A. W. Robinson

CALL THE  
DRS. OFFICE CLERK  
AT 3:00 P.M. TUES.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Clayton Barnes

Licensed Embalmer No. 4793

P. O. Address K.C., Mo.

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