

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 4 1960

=60-001898

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 464

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>JACKSON</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City, Mo</b>		Length of stay in 1b <b>50 yrs.</b>		c. CITY OR TOWN <b>Kansas City, Mo</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>6216 FOREST AVE</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6216 Forest</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mirtie</b> Middle <b>R</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>January</b> Day <b>23,</b> Year <b>1960</b>				
5. SEX <b>F</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-19-87</b>	9. AGE (last birthday) <b>72</b>	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) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>BLACKWATER MO.</b>		11. BIRTHPLACE (City and state or country) <b>USA</b>			
13a. FATHER'S NAME <b>JOSEPH JEFFRESS</b>			13b. MOTHER'S MAIDEN NAME <b>GEORGE ANN POTTER</b>			14. NAME OF HUSBAND OR WIFE <b>GEORGE W. 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>497 26 3361</b>		17. INFORMANT Address <b>GEORGIA McGUIRE 6216 FOREST AVE.</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>Congestive heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
DUE TO (b) <b>Arteriosclerotic heart disease</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 a.m. 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>2-11-58</b> to <b>1-23-60</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>1-15-60</b>				Death occurred at <b>8:00 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS <b>5801 Kingslee, Hickman Mills Mo</b>			22c. DATE SIGNED <b>1-25-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1 26 60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. WASHINGTON CEM</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MO.</b>			
24. FUNERAL DIRECTOR <b>D. W. NEWCOMER'S SONS K.C. MO.</b>				25. DATE RECD. BY LOCAL REG. <b>1-26-60</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

(Licensed Embalmer's Statement on Reverse Side)

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Wern Lawler

Licensed Embalmer No. 4915

P. O. Address H C Me

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.