

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-019381

STATE FILE NUMBER

FILED VS JUN 6 1960 149

Primary Registration District No. 1002 Registrar's No.

2839

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 job <b>36 yrs</b>	c. CITY OR TOWN <b>LEE'S SUMMIT</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3524 PEEK DRIVE</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>207 WILSON ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>Belle</b> Last <b>Fallis</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>23</b> Year <b>1960</b>		
5. SEX <b>FEMALE</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>MAY 7, 1882</b>	9. AGE (last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months Days 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	11. BIRTHPLACE (City and state or country) <b>MACON MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>WINFIELD SCOTT SMITH</b>		13b. MOTHER'S MAIDEN NAME <b>MELLISSA J. SMITH</b>		14. NAME OF HUSBAND OR WIFE <b>ATHOL CARY 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>NONE</b>	17. INFORMANT Address <b>MRS. S. P. McCONNELL 2104 W. 74th TERR</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 occlusion</b> DUE TO (b) <b>Arteriosclerotic Heart disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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>Apr 1, 1960</b> to <b>May 23, 1960</b> and last saw <del>him</del> <b>her</b> alive on <b>May 22, 1960</b> Death occurred at <b>330 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Don A. Black</i> (Degree or title)			22b. ADDRESS <b>M.D. 924 Professional Bldg.</b>		22c. DATE SIGNED <b>5/24/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>	<b>MAY 25, 1960</b>	<b>BLUE SPRINGS CEM</b>		<b>BLUE SPRINGS MO.</b>	
24. FUNERAL DIRECTOR <b>SD. W. NEWCOMER'S SONS KC. MO.</b>			25. DATE RECD. BY LOCAL REG. <b>5-25-60</b>		26. REGISTRAR'S SIGNATURE <i>Neva Trinchall</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
DON A. BLACK

**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 Thomas W. Holson

Licensed Embalmer No. 4889

P. O. Address D.C., 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.