SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-029635
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4192

FILED AUG 31 1961

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 3 YRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION General Hospital
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Clay
c. CITY OR TOWN Kansas City N.
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 6104 N Drury
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Frank Middle Last Smith

4. DATE OF DEATH Month 8 Day 20 Year 61

5. SEX male
6. COLOR OR RACE White
7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐ married
8. DATE OF BIRTH 8-12-1887
9. AGE (last birthday) 74
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) Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Phelps Co. Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME James Smith
13b. MOTHER'S MAIDEN NAME Naomi Brown
14. NAME OF HUSBAND OR WIFE Beda Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.
17. INFORMANT Mrs. Beda Smith Address 6104 N Drury

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute leukemia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
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 7-29-61, to 8-20-61 and last saw ~~her~~ him alive on 8-20-61
Death occurred at 2:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Frank Ellis (Degree or title) M.D.
22b. ADDRESS 2400 Cherry
22c. DATE SIGNED 8-21-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 8-24-61
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.
23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.

24. FUNERAL DIRECTOR D.W. Newcomer Sons ADDRESS N.K.C.
25. DATE RECD. BY LOCAL REG. 8-22-61
26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. SHOULD READ INSTEAD OF DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION

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 Glenn H. Hill

Licensed Embalmer No. 4586

P. O. Address K.C. 18 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.