

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-027476
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 325

FILED JUL 17 1962

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) Independence		Length of stay in 1b 41 yrs	c. CITY OR TOWN Independence Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT a hospital, give location) HOSPITAL OR INSTITUTION Sky View Manor 1400 North River		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1400 North River Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First FRANK Middle J. Last SMETZER			4. DATE OF DEATH Month July Day 6 Year 1962		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1872	9. AGE (last birthday) 89	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker	10b. KIND OF BUSINESS OR INDUSTRY R.C. No. Board of Education	11. BIRTHPLACE (City and state or country) Shreeve, Ohio	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Obad Smetzer	13b. MOTHER'S MAIDEN NAME Martha Dye	14. NAME OF HUSBAND OR WIFE Lola Smetzer	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mr. George Smetzer, 12307 E. 47th Terr. Address Independence, Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bilateral Pulmonary Edema	
DUE TO (b)	Cardiac Decompensation	3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	5 days
	Coronary occlusion	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Left inguinal hernia	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
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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.)
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20c. TIME OF INJURY Hour 7:10 a.m. p.m.	Month, Day, Year Dec. 1957
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Independence, Mo.	COUNTY	STATE
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21. I attended the deceased from **7:10** to **7-6-62** and last saw him alive on **7-3-62**
Death occurred at **7:10** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) E. H. Branch MD	22b. ADDRESS 10901 Winner Road Independence, Mo.	22c. DATE SIGNED 7/6/62
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23b. BURIAL, CREMATION, REMOVAL (Specify) Burial	23c. DATE July 9, 1962	23d. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery	23e. LOCATION (City, town, or county) Kansas City, Missouri
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24. FUNERAL DIRECTOR Melody-McGilley-Eyler Funeral Home 1800 E. Linwood	25. DATE RECD. BY LOCAL REG. 7-8-62	26. REGISTRAR'S SIGNATURE Alba L. Craig
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(Licensed Embalmer's Statement on Reverse Side)

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

An Erwin Dorach
10901 Winslow Rd

Res. 3516 Claremont

Englewood Med. Bldg.
CC 2-2344

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

Robert J. Landes

Licensed Embalmer No. 5103

P. O. Address K.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.