

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034996

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4884 STATE FILE NUMBER

FILED OCT 8 1962

VS 300
Rev. 4/59

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2 538
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4 2
5 0
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7 0
8 0
98889
10 46
11 123
1276-3
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DATE AMENDED 10-1-62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF 3611 Paseo

DOCUMENT

BY AFFIDAVIT OF Mrs. Lillie Miller

L. M. Tillman

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ 2d. 3611 Wabash

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) OR TOWN KANSAS CITY		Length of stay in 1b Life	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V A HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3611 Paseo - WABASH Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM REED SMITH			4. DATE OF DEATH Month Day Year September 20, 1962
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-20-22
9. AGE (last birthday) 40		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, kitchen		10b. KIND OF BUSINESS OR INDUSTRY General Hospital	11. BIRTHPLACE (City and state or country) Kansas City, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Robert Smith	
13b. MOTHER'S MAIDEN NAME Lillie Saulsbury		14. NAME OF HUSBAND OR WIFE ----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT VA Hospital Official Records, K.C. Mo		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Suspicion of drug intoxication (?)			
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 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.) Brought into Hospital in unconscious condition	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	unknown History unknown		
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.) unknown	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. Attended the deceased from Sept. 19, 1962 to Sept. 20, 1962 Death occurred at 8:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>L. M. Tillman M.D.</i>		22b. ADDRESS 1618 Lydia Ave.	22c. DATE SIGNED 9/22/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/26/62	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Fort, Leavenworth, Kansas
24. FUNERAL DIRECTOR Mrs. Meek's Mortuary K.C. Mo.		25. DATE RECD. BY LOCAL REG. 9-24-62	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

USE BLACK INK OR TYPEWRITER RIBBON

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

Willard B. Perkins

Licensed Embalmer No.

5013

P. O. Address

A.C. MD

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.