MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

40840

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. 5247
Township Raw — Primary Registration District No. 1002 — Registered No.
City Kansas City Mo (No. Raywood Apt St. Ward)

2. FULL NAME Alexander Smith
(a) Residence. No. N. E. Cor. 26-th & Troost St., 4 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lillian B. Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 28-1886

7. AGE: Years 43 — Months 4 — Days 21 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Salesman For Power
(b) General nature of industry, business, or establishment in which employed (or employer): Mfg Co-Manchester Ohio
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Hold Mich

PARENTS
10. NAME OF FATHER: Noah Smith
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Mrs Lillian B. Smith
(Address) Raywood Apt. 26th & Troost

15. FILED 12/20, 1929 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 19 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1929, to Dec. 19, 1929 that I last saw him alive on Dec. 18, 1929 and that death occurred, on the date stated above, at 7:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Aortic Insufficiency
92 A
130 (duration) yrs. 8 mos. ds.

CONTRIBUTORY (SECONDARY) Acute Nephritis
(duration) yrs. 1 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Leo Jones, M. D
12/19/29 (Address) 80th & Paseo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. [redacted], CREMATION, [redacted]
Cremation-Elmwood Cem
DATE OF BURIAL Dec. 21 1929

20. UNDERTAKER A. P. Doehler
ADDRESS 1415 E 15

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD