

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.

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

13879  
Do not use this space.

REC'D MAY 10 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Law Primary Registration District No. 1002  
 (c) City Kansas City (d) Street No. St Joseph Hospital Registered No. 1633  
 (If death occurred in hospital or institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (9) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Herbert A. Smith  
 (a) Residence, No. 3214 Bellefontaine St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

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 Kathleen Smith

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 21-1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
59 10 25-

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Engineer for Telephone Co.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

FATHER 13. NAME Anson Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

MOTHER 15. MAIDEN NAME Bigail Larnmouth

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

17. INFORMANT (ADDRESS) Mrs Kathleen Smith  
3214 Bellefontaine

18. BURIAL, CREMATION, OR REMOVAL PLACE Clatte City, Mo DATE 4/18 1939

19. FUNERAL DIRECTOR (ADDRESS) Flint-McClure  
Kansas City, Mo.

20. FILED Apr 18, 1939 M. Brown  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 16, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 27, 1939 to April 16, 1939  
 I last saw him alive on April 16, 1939. Death is said to have occurred on the date stated above, at 8 A. m.  
 The principal cause of death and related causes of importance were as follows:

General septicemia, from peritoneal abscess. Bilateral hydrothorax.  
 129  
 Other contributory causes of importance: Cause of abscess of undetermined.

Name of operation none Date of X  
 What test confirmed diagnosis? X Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? X Date of injury X, 1939  
 Where did injury occur? X (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury X  
 Nature of injury X

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify no  
 (Signed) [Signature] M. D.  
 (Address) 1025 Argyle Bldg. K. S. Mo.

original B.C. 1/1/11

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**STATEMENT BY LICENSED EMBALMER**

I, ....., Licensed Embalmer No.....  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....  
..... L. E.....  
No..... or by....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

**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.)**