

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

21284  
Do not use this space.

REC'D JUL 10 1939

1. PLACE OF DEATH  
 (a) County Jackson 2 Registration District No. 399  
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 2552  
 (c) City Kansas city 1 (d) Street No. 1227 Woodland Ave St.  
 (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. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 530 Peggy Smith  
 (a) Residence, No. 1227 Woodland Ave St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) child  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF child  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-13-1934  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
5 2 20  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. child  
 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) Kansas city, Missouri

FATHER  
 13. NAME Wm Smith 0  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown 9  
 MOTHER  
 15. MAIDEN NAME Alvina Smith  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Okla

17. INFORMANT (ADDRESS) Mr. Wallace Bruce  
641 Georgia Ave  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge DATE 6-26-39, 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. B. Moore  
1820 E-19th St.  
 20. FILED 6/24, 1939 M. M. Crome  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-3- 1939  
 22. I HEREBY CERTIFY, That I attended deceased from 1939 to 1939.  
 I last saw him Deputy Coroner, 19..... Death is said to have occurred on the date stated above, at 8 P. m.  
 The principal cause of death and related causes of importance were as follows:  
Sudden Flaccid Paralysis  
Acute Pulmonary Edema  
 Date of onset  
 Other contributory causes of importance: 179  
 Name of operation..... Date of.....  
 What test confirmed diagnosis? Cul Was there an autopsy?.....  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide Accident Date of injury.....  
 Where did injury occur? Home (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury at Sudden Paralysis by Myocardial  
 Nature of injury.....  
 24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify.....  
 (Signed) Deputy Coroner, M. D.  
 (Address) Home

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**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 .....

Registered Apprentice No....., working under my personal supervision.

Signed..... *H. B. Moore* .....

Licensed Embalmer No..... *2410* .....

P. O. Address..... *K. C. Missouri* .....

**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 this body is not embalmed, above space should be left blank.**