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.

REC'D SEP 6 1939

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

28320
Do not use this space.

1. PLACE OF DEATH
(a) County JACKSON 2 Registration District No. 399
(b) Township RAW Primary Registration District No. 1002 Registered No. 3322
(c) City KANSAS CITY (d) Street No. 712 - WEST - 74TH 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 530 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MRS. HELEN BLAIR SMITH
(a) Residence, No. 712 - WEST - 74TH St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
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 ALLEN C. SMITH
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAY - 9 - 1880
7. AGE: Years 59 | Months 3 | Days 11 | If LESS than 1 day, ...hrs. or ....min.

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

12. BIRTHPLACE (CITY OR TOWN) BELLEVILLE (STATE OR COUNTRY) ONTARIO, CANADA 2

FATHER
13. NAME HUGH BLAIR 2
14. BIRTHPLACE (CITY OR TOWN) BELLEVILLE 2 (STATE OR COUNTRY) ONTARIO, CANADA

MOTHER
15. MAIDEN NAME EMMA J. GRIFFIN
16. BIRTHPLACE (CITY OR TOWN) BELLEVILLE (STATE OR COUNTRY) ONTARIO, CANADA

17. INFORMANT MR ALLEN C. SMITH (ADDRESS) 712 - WEST - 74TH STREET
18. BURIAL, CREMATION, OR REMOVAL PLACE MT. MORIAH DATE AUGUST - 22, 1939
19. FUNERAL DIRECTOR (NAME) D.W. NEWCOMER'S SONS (ADDRESS) 1401 - BRUSH CREEK
20. FILED 8-22, 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) AUGUST - 20, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1934, to Aug 20, 1939
I last saw her alive on Aug. 19, 1939. Death is said to have occurred on the date stated above, at 3:30 A.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic adhesive pericarditis	1890
Mitral regurgitation (Relative)	1900
Arterial hypertension	1937
Bronchial asthma 52 yr	1934

Other contributory causes of importance:

Chronic passive congestion of lungs and liver	Nov. 1938
Generalized anasarca	Apr. 1939

Name of operation None Date of
What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ....., 19....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) James H. Danglade, M. D.
(Address) 315 Alameda Road K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

2nd Plaza Medical Bldg
2-5

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 E. M. Calhoun

Licensed Embalmer No. 3506

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