

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.

NOV 14 1939

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

**34836**  
Do not use this space.

**1. PLACE OF DEATH**

(a) County JACKSON Registration District No. 399  
 (b) Township RAW Primary Registration District No. 1002  
 (c) City KANSAS CITY (d) Street No. 214 WABASH Registered No. 3811  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (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**

DR. ELMORE OSCAR SMITH  
 (a) Residence, No. 214 WABASH 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) WIDOWED  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF MRS. MARY A. SMITH  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCT-3-1850  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 88 11 25  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. CANCER & SKIN  
 9. Industry or business in which work was done, as saw mill, bank, etc. SPECIALIST  
 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) BURNE NEW YORK

FATHER 13. NAME HENRY O. SMITH  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ROCHESTER NEW YORK

MOTHER 15. MAIDEN NAME SARAH STOWERS  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) VERMONT

17. INFORMANT (ADDRESS) MRS PEARL A. WELDON 214 WABASH AVENUE

18. BURIAL, CREMATION, OR REMOVAL PLACE FOREST HILL DATE OCTOBER 2, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) D. W. NEWCOMER'S SONS 1401 BRUSH CREEK BLVD

20. FILED 10/2/39 1939 m. m. brown Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) SEPT. 28, 1939

22. I HEREBY CERTIFY, That I attended deceased from MARCH 21, 1939, to SEPTEMBER 28, 1939  
 I last saw him alive on SEPTEMBER 28, 1939. Death is said to have occurred on the date stated above, at 8:15 P.M.  
 The principal cause of death and related causes of importance were as follows:

Myocarditis, Chr  
930  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance:  
Royal-Bladder  
Obcess non tuberculous  
no. malignancy

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? 2  
 If so, specify \_\_\_\_\_  
 (Signed) Samuel Kerner M.D.  
 (Address) 1102 Waldheim Bldg  
361

K. E. MO

**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 *Emile 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.**