

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1913**

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Lama City Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Trinity Lutheran Hospital  
 (If not in hospital or institution, write street number & location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days \_\_\_\_\_

3. (a) PRINT FULL NAME Vera Smith **530**  
 3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Female 5. Color of race White 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife Red Smith 6. (c) Age of husband or wife if alive 47 years  
 7. Birth date of deceased Sept 3 1903  
 (Month) (Day) (Year)

| 8. AGE: | Years     | Months    | Days     | If less than one day |
|---------|-----------|-----------|----------|----------------------|
|         | <u>36</u> | <u>18</u> | <u>5</u> | hr. _____ min. _____ |

9. Birthplace \_\_\_\_\_ (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name Harry Thompson  
 { 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
 { 14. Maiden name Margaret Wagner  
 { 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Red Smith

(b) Address Harrisonville, Mo.

17. (a) Burial (b) Date thereof 8-9-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nevada, Mo., Deepwood, Mo.

18. (a) Signature of funeral director Harry Thompson  
 (b) Address Nevada, Mo.

19. (a) May 7, 1940 (b) M. M. Brown  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Basin  
 (c) City or town Harrisonville  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 20 1/2 E. Wall St  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6th day May  
 year 1940 hour 2:30 minute P M.  
 21. I hereby certify that I attended the deceased from May 2-1940  
 \_\_\_\_\_, 19\_\_\_\_, to May 6, 1940  
 that I last saw her alive on May 6, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death acute nephritis - pneumonia  
 Due to Chlamydia - of 2 days standing before entering hospital  
 Due to 8 months pregnancy  
 Other conditions peritonitis section 5-2-40  
 (include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy 146  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 \_\_\_\_\_  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury fall  
 23. Signature Ind. J. Neppay (M. D. or other) \_\_\_\_\_  
 Address Professional Bldg Date signed 5-8-40

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.

OCT 6 1944

AUG 6 1958

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. \_\_\_\_\_  
 (b) Township Mo. Mo Primary Registration District No. \_\_\_\_\_ Registered No. 1913  
 (c) City \_\_\_\_\_ (d) Street No. Community Hospital 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 Vera Smith  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

|        |       |        |      |  |
|--------|-------|--------|------|--|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, _____ hrs. or _____ min. |
|--------|-------|--------|------|--|

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. \_\_\_\_\_

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) \_\_\_\_\_

FATHER

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED May 7 1940 M. M. Brome Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 6 1940

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:  
acute nephritis  
pneumonia  
decompression of 2 day standing before entering hospital  
other contributory causes of importance:  
mother delivered 5/3/40

Date of onset 146

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? \_\_\_\_\_  
 If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.  
 (Address) \_\_\_\_\_

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-17386