

No. 25  
4-13-40  
5-17-39  
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

U.S. DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

# MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. 34378  
3894  
Registrar's No. \_\_\_\_\_

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Missouri.

(c) Name of hospital or institution: 204 Commodore Hotel **2**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community Fifty Two Years

years, months or days

3. (a) PRINT FULL NAME Mrs Delia Smith

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Jacob Smith 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased March 17th, 1865

(Month) (Day) (Year)

8. AGE: Years 75yrs Months 6 Days 18 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace New York New York **1**

(City, town, or county) (State or foreign country)

10. Usual occupation Housewife **5**

11. Industry or business At Home **5**

12. Name James Flaherty

13. Birthplace CountyCork Ireland

(City, town, or county) (State or foreign country)

14. Maiden name Mary KYNE

15. Birthplace Ireland

(City, town, or county) (State or foreign country)

16. (a) Informant Arthur L. Smith

(b) Address 2617 Linwood, K.C. Mo.

17. (a) Burial (b) Date thereof 10/8/40.

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Mellody-McGilley

(b) Address K. C. Mo.

19. (a) Oct. 8, 1940 (b) M. M. Browne

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas, City

(If outside city or town limits, write "RURAL")

(d) Street No. 204 Commodore Hotel

(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5th

year 1940 hour 1:00 minute P.M.

21. I hereby certify that I attended the deceased from 9/5

\_\_\_\_\_ 1939 to \_\_\_\_\_ 1940

that I last saw her alive on 9/25 \_\_\_\_\_ 1940

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Progressing Stomach & Intestinal Cancer

Due to 4/6

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy Carcinoma of Stomach & Intestines

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? \_\_\_\_\_

23. Signature M. M. Browne (M. D. or other) \_\_\_\_\_

Address 870 Professional Bldg Date signed 10/8/40

Duration 1 yr

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

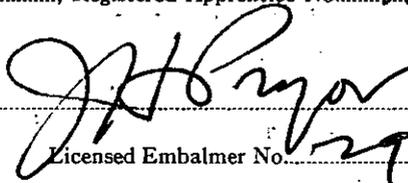
**STATEMENT BY LICENSED EMBALMER**

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. 267

working under my personal supervision.

Signed.....

  
.....  
Licensed Embalmer No. 2989

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, fact should be so stated above.**