

NOV 12 1940

Registration District No. _____

Primary Registration District No. **1002**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Mary's**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **2 Days** years, months or days)

3. (a) PRINT FULL NAME **John Francis Smith**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Ma** 5. Color or race **Wh** 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife **Infant** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Oct. 20, 1940**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
-- -- 2 hr. _____ min.

9. Birthplace **Kansas City Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Infant**

11. Industry or business _____

MOTHER FATHER { 12. Name **James Smith**
13. Birthplace **Ireland** (City, town, or county) (State or foreign country)
14. Maiden name **Anna Russell**
15. Birthplace **Ireland** (City, town, or county) (State or foreign country)

16. (a) Informant **James Smith**
(b) Address **3912 Central**

17. (a) **Burial** (b) Date thereof **10-23-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Mary's**

18. (a) Signature of funeral director **Thos. E. Quirk**
(b) Address **4316 Troost**

19. (a) **10-23-40** (b) **M. M. Brown**
(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")
0 **3912 Central**
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **22**
year **1940** hour _____ minute **a** M.

21. I hereby certify that I attended the deceased from **10-20-40** to **19** _____, 19 _____;
that I last saw him alive on **10-21**, 19 **1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Failure of lung to expand after birth** Duration _____

Due to _____

Due to _____

Other conditions _____ (Includes pregnancy within 3 months of death) **16/00**

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

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 _____

23. Signature **J. J. Bennett** (M. D. or other) _____
Address **410 Argyle Bldg.** Date signed **10/22/40**

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 Thomas Equick

Licensed Embalmer No. 3775

P. O. Address A. 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.