

399

1002

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. **4303**

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 K.C. General Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 22 days  
(Specify whether  
In this community 18 yrs  
years, months or days)

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")  
Street No. 3409 Holmes St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME BARBARA SMITH

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Edison C. Smith 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 27 1862  
(Month) (Day) (Year)

8. AGE: Years 78 Months 5 Days 13 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Wis. Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation at home

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

12. Name Wanner

18. Birthplace Ger  
(City, town, or county) (State or foreign country)

14. Maiden name No Record

15. Birthplace Ger  
(City, town, or county) (State or foreign country)

16. (a) Informant Gen W. Smith

(b) Address Oklahoma City Oklahoma

17. (a) Removal (b) Date thereof Nov. 11-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grand Rapids Mich

18. (a) Signature of funeral director Mr. C.R. Foster

(b) Address 718 Brooklyn K.C. Mo

19. (a) 11-11-40 (b) M. M. Grove  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10th  
year 1940 hour 8 minute 10 A. M.

21. I hereby certify that I attended the deceased from 10-19-40, 19\_\_\_\_, to 11-10-40, 19\_\_\_\_;

that I last saw her alive on 11-10-40, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Recent surgical drainage of gall bladder for cholelithiasis Duration  
Diverticulitis with rupture and Peritonitis.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 126

Of autopsy See above

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 D.P. Thum (M., D. or other) \_\_\_\_\_

Address Med. Dir. K.C. Gen. Hospital Date signed \_\_\_\_\_

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

FILED DEC 11 1940

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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.**