

FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2851

Registration District No. 998

Primary Registration District No. 3019

Registrar's No. 29

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

1. PLACE OF DEATH:
 (a) County JACKSON
 (b) City or town INDEPENDENCE
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
711 S. FULLER AVE /
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 38 YEARS years, months or days

3. (a) PRINT FULL NAME MRS. HARRIETT 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 HYRUM O. SMITH
 6. (c) Age of husband or wife if alive 85 years
 7. Birth date of deceased: 4 (Month) 14 (Day) 1857 (Year)

8. AGE: Years 83 Months 9 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace LLANELLY'S WALES 4
 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business NONE

MOTHER FATHER
 12. Name WILLIAM MASTERS
 13. Birthplace NO RECORD WALES 4
 (City, town, or county) (State or foreign country)
 14. Maiden name JANET LLEWELLYN
 15. Birthplace NO RECORD WALES 4
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. A. Gardner
 (b) Address 711 S. Fuller, Indep. Mo.

17. (a) BURIAL (b) Date thereof 1-24-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOUND GROVE

18. (a) Signature of funeral director Hubstalt

(b) Address 815 W. Maple Ave. Indep. Mo.

19. (a) Jan 29-41 (b) A. P. Cook M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County JACKSON 48
 (c) City or town INDEPENDENCE 4
 (If outside city or town limits, write "RURAL") 7
 (d) Street No. 711 S. FULLER AVE
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 77 years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 22
 year 1941 hour TWO minute _____ A. M.

21. I hereby certify that I attended the deceased from Nov. 2, 1941 to Jan 21, 1941, that I last saw him alive on Jan 21, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Parotitis!
left
Cerebral Hemorrhage
of left hemisphere
Generalized
arteriosclerosis

Duration
1 wk
6 wks
?

Other conditions (Include pregnancy within 3 months of death)

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? _____

3:00
 While at work _____ (Specify type of place)
 _____ (b) Means of injury

23. Signature J. A. Gardner (M. D. or other) _____
 Address Indep. Mo. Date signed 1/24/41

822

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

Henry W. Stahl

Licensed Embalmer No.

3181

P. O. Address

Independence 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2857

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 398

Primary Registration District No. 3019

Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Independence
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

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

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

In this community years, months or days (Specify whether)

3. (a) PRINT FULL NAME: Mrs Harriett Smith

3. (b) If veteran, name war.

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: m

6. (b) Name of husband or wife.

6. (c) Age of husband, or wife, if alive. year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

83 9 8 hr. min.

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

10. Usual occupation.

11. Industry or business.

MOTHER FATHER { 12. Name.

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

14. Maiden name. (City, town, or county) (State or foreign country)

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

16. (a) Informant.

(b) Address.

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

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) (Received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. (b) County.

(c) City or town. (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

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

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22 year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Peritonitis
Cerebral Hemiparesis
Due to Left Hemiplegia
Generalized
Due to Arteriosclerosis

Other conditions: Acute infectious suppurative peritonitis Jan 18, 1941

Major findings: Not mummified

Of operations: \$30

Of autopsy:

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: Chas Kratzke (M. D. or other) Address: Independence Date signed: 4/11/41

PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

