

No. 2
1-4-41
7-39
28390

DEC 22 1941 399

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 4108

1. PLACE OF DEATH:

(a) County Jackson County
(b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Children's Mercy Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 10 Days
In this community 10 Days
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 5
(c) City or town Cassville, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 1
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Leon Smiley

3. (b) If veteran, name war NO

3. (c) Social Security No. NO

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Feb 19 1940
(Month) (Day) (Year)

8. AGE: Years 1 Months 8 Days 15 hr. _____ min. _____
If less than one day

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Thomas Smiley

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

14. Maiden name Dona Chapman

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

16. (a) Informant Thomas Smiley

(b) Address Cassville, Mo

17. (a) Burial (b) Date thereof 11-5-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shell Knob - Shell Knob Mo

18. (a) Signature of funeral director Family

(b) Address _____

19. (a) 11-4-41 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 4
year 1941 hour 6:00 minute _____ A. M.
21. I hereby certify that I attended the deceased from October 25
1941 to Nov. 4 1941
that I last saw him alive on November 4 1941
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Multiple Abscesses of the Lung
Due to Empyema
Due to pneumonia
Other conditions (Include pregnancy within 3 months of death) _____

Duration

Major findings: Of operations _____
Of autopsy same 113

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 0
23. Signature A. B. [unclear] (M. D. or other) _____
Address 132 E. [unclear] Date signed [unclear]

4-4

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

MOTHER FATHER

10/1/54
J. A. [unclear]

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **4108**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town.....
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Children's Mercy Hospital
 (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)

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) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Leon Smiley**

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

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

8. AGE: Years Months Days If less than one day
1 8 15
 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.....
 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) **11/4/41** (b) **M. M. Crowe** (Registrar's signature)
 (Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **4**
 year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from **Nov 4**
 19 **41** to **Nov 4**, 19 **41**
 that I last saw **last** alive on **Nov 4**, 19 **41**
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Multiple Abscesses of the lung
empyema/pneumonia pyogenic
Streptococcus

Due to.....
 Due to.....
 Other conditions..... (Include pregnancy within 3 months of death) **114 D**

PHYSICIAN
 Major findings:
 Of operations.....
 Of autopsy..... **Same**
 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) (County) (State) Means of injury.....
 23. Signature **W.B. S. ...** (M. D. or other)
 Address **1316 Prop. Bldg.** Date signed **Dec**

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

SUPPLEMENTARY

S-37314

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, fact should be so stated above.