

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6332

State File No. _____
Registrar's No. 792

FILED MAR 6 1944
Registration District No. 749

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:
2629 Euclid /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community 42 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William G. Smith

3. (b) If veteran, name war None

3. (c) Social Security No. 703-03-3703

4. Sex M

5. Color or race Col

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

6. (b) Name of husband or wife Susie Smith

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased August 4 1894
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>49</u>	<u>6</u>	<u>8</u>	hr. _____ min. _____

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

10. Usual occupation Butcher

11. Industry or business Swift and Co.
Rendy Smith

12. Name _____

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

14. Maiden name Mary Giles

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

16. (a) Informant Susie Smith

(b) Address 2629 Euclid

17. (a) burial (b) Date thereof 2/15/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Mathews Bros

(b) Address 1729 Lydia

19. (a) 2-17-44 (b) D. C. 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")

(d) Street No. 2629 Euclid
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 12th
year 1944 hour 5:30 minute A. M.

21. I hereby certify that I attended the deceased from 5:00
10 - 1944 to Feb 13 1944
that I last saw h. alive on Feb 5 - 1944
and that death occurred on the date and hour stated above.

Immediate cause of death ruptured abdominal aorta

Due to _____

Due to _____

Other conditions (include presence within 3 months of death) abdominal Hernia

Major findings: Operation 1-5-44

Of operations _____

Of autopsy No

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)

(c) Means of injury 0

23. Signature D. C. Brown (M. D. or other) _____

Address 804 Brown Date signed _____

844

(Licensed Embalmer's Statement on Reverse Side)

D. C. Brown

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 *D. J. Manlove*

Licensed Embalmer No. *3994*

P. O. Address *2503 Highland*

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.