

FILED MAY 11 1944
Registration District No. **199**

Primary Registration District No. **1002**

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:
Conley Clinical Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days** (Specify whether
In this community **5 days** years, months or days)

3. (a) PRINT FULL NAME **Herbert Henry Smith**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Caroline A. Smith** 6. (c) Age of husband or wife if alive **2** years

7. Birth date of deceased **June 9, 1860**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 10 26 hr. min.

9. Birthplace **Ossining, New York**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Self**

12. Name **Jason L. Smith**

13. Birthplace **Sophia M. Pushee New York**
(City, town, or county) (State or foreign country)

14. Maiden name **Sophia M. Pushee**

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

16. (a) Informant **Mrs. Jessie Casey**

(b) Address **2117 Belleview Ave, K.C. Mo.**

17. (a) **Removal** (b) Date thereof **5/8/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Park**
Geo. H. Long
18. (a) Signature of funeral director **Geo. H. Long**
(b) Address **Kansas City, Kansas**

19. (a) **5-6-44** (b) **W. E. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Branch** (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **5**
year **1944** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **5-4**
1944 to **5-5-44** 19 **44**
that I last saw him alive on **5-5-44** and that death occurred on the **5-5-44** and hour stated above.

Immediate cause of death **Lower Hypostatic Pneumonia** Duration **12 hrs**

Due to **Prostatitis retention**

Due to **Senility**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **108**
Of operations _____

Of autopsy **As 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) Means of injury _____

23. Signature **John T. Roney** (M. D. or other) **do**

Address **2108 Independence Ave** Date signed **5-5-44**

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

MOTHER FATHER

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..... *Chas. H. Rider*
Licensed Embalmer No. *3404*
P. O. Address *703 N. 10th St. K.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, fact should be so stated above.