

FILED APR 29 1944

Registration District No. 148

Primary Registration District No. 3026

Registrar's No. 64

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: Independence Sanitarium & Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Days
(Specify whether
In this community 25 Years
years, months or days)

3. (a) PRINT FULL NAME ROBERT SMITH

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex: Male (1) 5. Color or race: White 6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Nettie T. Smith 6. (c) Age of husband or wife if alive: 72 years
7. Birth date of deceased: March 6, 1868
(Month) (Day) (Year)

8. AGE: Years 76 Months 0 Days 19 If less than one day hr. _____ min.

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

10. Usual occupation: Farmer

11. Industry or business _____

MOTHER FATHER

12. Name: Robert Smith
13. Birthplace: England (City, town, or county) (State or foreign country)
14. Maiden name: No Data
15. Birthplace: No Data (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Nettie T. Smith
(b) Address: Independence, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/27/44 (Month) (Day) (Year)
(c) Place: burial or cremation: Mound Grove Cemetery

18. (a) Signature of funeral director: Voland P. Sparks
(b) Address: Independence, Missouri
19. (a) 3/27/44 (Date received local registrar) (b) James Ross (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Rural Blue
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. #3 Indep. Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25
year 1944 hour 1 minute 25 P. M.

21. I hereby certify that I attended the deceased from Mar 14 1944 to Mar 25 1944
that I last saw him alive on Mar 25 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary thrombosis
Due to Retained Pericard and operation
Due to _____

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

Major findings: 9/4
Of operations _____

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) (or) Means of injury _____
23. Signature: [Signature] (D. or other) _____
Address: Independence, Mo. Date signed 3-28-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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. *3604*

P. O. Address *Indep, 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.