

FILED MAR 19 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

1002

Registrar's No. 992

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:  
General Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2-20-45-2-20-45  
(Specify whether years, months or days) 22 Yrs

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. 2419 Charlotte  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Arthur Smith

3. (b) If veteran, name war no 3. (c) Social Security No. 495-10-5924

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Lillie Mae Smith 6. (c) Age of husband or wife if alive 43 years  
7. Birth date of deceased May 12 1900  
(Month) (Day) (Year)

8. AGE: Years 44 Months 9 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Auto Mechanic

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Lloyd Smith  
13. Birthplace Shreveport, La.  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace La.  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk  
(b) Address Gen. Hosp.  
17. (a) Burial (b) Date thereof March 1, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lincoln Cemetery, K.C., Mo.

18. (a) Signature of funeral director: Fannie L. Meek  
(b) Address 1708 E. 18th St., K.C. Mo.  
19. Mar 1-1945 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 20 year 1945 hour 10:45 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from February 20 1945 to February 20 1945  
that I last saw him alive on February 20 1945  
and that death occurred on the date and hour stated above.  
Immediate cause of death Cerebral Hemorrhage Duration \_\_\_\_\_

Due to Hypertension

Due to \_\_\_\_\_  
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? MO.  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
Means of injury \_\_\_\_\_  
23. Signature J. E. Brown (M.D. or other) \_\_\_\_\_  
Address Gen Hosp #2-608 E 22 Date signed 2-23-45

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

JUL 16 1947

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 Fannie G. Meek

Licensed Embalmer No. 3818

P. O. Address Kansas City, 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.**