

No. 2
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-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8859

FILED APR 6 1946

State File No. _____

Registration District No. 72

Primary Registration District No. 4134

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Smithville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Smithville Community Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay
(c) City or town Smithville
(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 Baby Park

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased march 26 46
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 6 hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name James Albert Park

13. Birthplace R.E. mo
(City, town, or county) (State or foreign country)

14. Maiden name Annabel Key Kendall

15. Birthplace Platte Co. mo
(City, town, or county) (State or foreign country)

16. (a) Informant Gas. A. Park
(b) Address 12 S. 14th St. R.C. Res

17. (a) 3-27-46 (b) Date thereof _____
(Month) (Day) (Year)

(c) Place: burial or cremation Platte Co. - mo

18. (a) Signature of funeral director S.A. Melonas
(b) Address Smithville - mo

19. (a) Mar 27 46 (b) Beulah Kitcher
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month march day 26 year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from March 26, 1946 to March 46, 1946 that I last saw him alive on March 46, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Immature fetus

Due to Premature Birth
Due to Placenta Previa

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

Major findings: Of operations _____ Of autopsy _____

Duration _____
Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED BY PHYSICIAN

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 _____

23. Signature [Signature] (M. D. or other) _____
Address Smithville Date signed 3/26/46

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 4-4-46

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 _____

Not Embalmed, Registered Apprentice No. _____

working under my personal supervision.

Signed S. A. McComas

Licensed Embalmer No. 2303

P. O. Address Smithville, 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.

Registration District No. 72

Primary Registration District No. 4134

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Smithville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME Park

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Mar 26
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (If less than one day)
hr. _____ min. mo

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 20
year 1949 hour 4:45 minute a M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 _____

23. Signature W. Spelman (M. D. or other) _____
Address Smithville Mo Date signed 4-12-49

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

SUPPLEMENTARY

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