

S. No. 2
M-5-43
5-17-39
I X36671

27370

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. **3748**

FILED SEP 14 1946
Registration District No. _____

Primary Registration District No. **1002**

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

26210

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: **Osteopathic Hospital**
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution **3 days**
In this community **59 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **2632 Cypress**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **NANNIE MAY SMITH**
(b) If veteran, name war **no**
(c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug.** day **31** year **1946** hour **3:55** minute **0** M.
21. I hereby certify that I attended the deceased from **Aug 18, 1946** to **Aug 31, 1946**
that I last saw her alive on **Aug 31, 1946**
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Henry J. Smith**
6. (c) Age of husband or wife if alive **64 years**
7. Birth date of deceased **Feb. 17 - 1887**
(Month) (Day) (Year)

Immediate cause of death **Chronic myocardial Basis & decompensation** Duration **3 weeks**
Due to **Essential hypertension** Eyes

8. AGE: Years **59** Months **5** Days **14** If less than one day hr. _____ min. _____

Due to _____
Other conditions: _____ (Include pregnancy within 3 months of death) **93D**

9. Birthplace _____ (City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

Major findings: _____
Of operations _____
Of autopsy **hypertrophy & dilatation of left ventricle, venous congestion**
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business **self**
12. Name **David Lipscomb**
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name **no information**
15. Birthplace _____ (City, town, or county) (State or foreign country)

12. 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?

16. (a) Informant **Mr. Henry J. Smith**
(b) Address **2632 Cypress**
17. (a) **Burial** (b) Date thereof **Sept. 3 - 1946**
(Burial, cremation, or removal) (City or town) (County) (State) (Day) (Year)
(c) Place: burial or cremation **Floral Hill**

18. (a) Signature of funeral director **Mrs. C. S. Foster**
(b) Address **918-20 Brooklyn**
19. (a) **8-31-46** **Alfredine Holmes**
(Date received local registrar) (Registrar's signature)
23. Signature **L. Raymond Hall** (M. D. or other) **no.**
Address **2603 Lindbergh Blvd** Date signed **8-31-46**

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(Date received local registrar) (Registrar's signature)

2603 Shively Ave
E. 0622

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..... *JOE B. Lyoder*

Licensed Embalmer No..... *4173*

P. O. Address..... *KC. 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.