

State File No. _____
 Registrar's No. **4549**

Registration District No. **177** Primary Registration District No. **1002**

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

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 **Trinity Lutheran Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **3 weeks** (Specify whether
 In this community **since 1901** years, months or days)

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. **436 West 70th Terrace,**
(If rural, give location)
 (e) Citizen of foreign country? **no.** (Yes or No)
 If yes, name country **x**

3. (a) PRINT FULL NAME **Samuel H. Smith, Jr.**
 3. (b) If veteran, name war **no.** 3. (c) Social Security No. **no.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **27**
 year **1946** hour **11:55** minute **P.** M.

4. Sex **male** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **widowed**
 6. (b) Name of husband or wife **Ella N. Smith**
 6. (c) Age of husband or wife if alive **dec.** years
 7. Birth date of deceased **December 14 1860**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
9 Oct 1946 to 27 Oct 1946
 that I last saw him alive on **27 Oct 1946**
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
85 10 13 hr. min.

Immediate cause of death **Chronic myocarditis** Duration **unknown**

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

Due to _____
 Due to _____

10. Usual occupation **Retired**

Other conditions **93rd**
(Include pregnancy within 3 months of death)

11. Industry or business **x**

Major findings: **Prostate Hypertrophy** **PHYSICIAN**
Of operations Underline the cause to which death should be charged statistically.

12. Name **unknown**

13. Birthplace **unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **unknown**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Samuel H. Smith, Jr.**

(b) Address **436 W. 70th Ter., K. C., Mo.**

17. (a) burial (b) Date thereof **10-29-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill Cemetery**

18. (a) Signature of funeral director **Stine & McClure**
3235 Gillham Plaza, K. C., Mo.

19. (a) 10-29-46 (b) **Sheraldine Holmes**
(Date received local registrar) (Registrar's signature)

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? _____
(Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature **N E Carlson** (M. D. or other) **MD**
1530 Prof Bldg Date signed **28 Oct 1946**

Dr. Carlson

Pony Building

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 *J. Clair Sheppard*
Licensed Embalmer No. *4179*
P. O. Address *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.