

FILED APR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 9409  
Registrar's No. 1503

Registration District No. 149

Primary Registration District No. 1002

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 15 Days  
(Specify whether  
In this community 60 years  
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. 3238 Tracy  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARY HELEN SMITH

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

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Milton J Smith  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 5 1865  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
82 0 24 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Alton - Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

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

12. Name Michael Carmody  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Fitzgerald  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Milton P. Smith  
(b) Address 810 East 4th St

17. (a) Burial (b) Date thereof 4/11/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Frank and Edwin Co  
(b) Address 20 West Linwood

19. (a) 3-31-47 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 29th day March  
year 1947 hour 11:35 minute A M.

21. I hereby certify that I attended the deceased from 3-14 1947, to 3-29 1947  
that I last saw h. lx alive on 3-29 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration 5 day

Due to Diabetes Mellitus 45 years

Due to Obesity - Cardiac Dilatation  
Senility - Arteriosclerosis  
Other conditions Old Venous Thrombosis

(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) no  
(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 fall

23. Signature Angela A. Quinn (M. D. or other) MD  
Address 1108 1/2 Smith Date signed 3-31-47

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

MOTHER FATHER

