

FILED JUN 23 1950

THE REPUBLIC OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29476
2514

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (In this place) 46 yrs		d. STREET ADDRESS (If rural, give location) 3301 Charlotte	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3301 Charlotte			

3. NAME OF DECEASED (Type or Print) a. (First) Maude b. (Middle) B. c. (Last) Smith			4. DATE OF DEATH (Month) (Day) (Year) June 3, 1950		
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	
8. DATE OF BIRTH Oct. 27, 1864		9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA		10b. KIND OF BUSINESS OR INDUSTRY	

13a. FATHER'S NAME William Flint		13b. MOTHER'S MAIDEN NAME Marguerite Marshall		14. NAME OF HUSBAND OR WIFE Orson T. Smith, deceased	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS O. F. Smith 3301 Charlotte	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Hemiplegia		DUE TO (c) old Cerebral hemorrhage		6 years	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						352 ^h	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from Dec. 1944, to June 3, 1950, that I last saw the deceased alive on June 3, 1950, and that death occurred at 3:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE Luella R. Conner (Degree or title) Luella R. Conner D.O.		23b. ADDRESS Raytown, Mo		23c. DATE SIGNED 6/3/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 6-6-50		24c. NAME OF CEMETERY OR CREMATORY Mount Washington		24d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
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DATE REC'D BY LOCAL REG. 6-5-50		REGISTRAR'S SIGNATURE Seraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE, Kansas City, Mo.	
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WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Luelle Conner
(coming by here)

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed

W. E. Wright

Licensed Embalmer No. *43-5-5*

P. O. Address *18 C. Ave*

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.