

FILED MAY 28 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **16178**  
**2100**

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

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>38 YEARS</b>		e. STREET ADDRESS (If rural, give location) <b>6046 Swope Parkway</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>6046 Swope Parkway</b>		f. STREET ADDRESS <b>3798</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Ivo</b>	b. (Middle) <b>BARNETTE</b>	c. (Last) <b>Smith</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>May 7, 1954</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>FEB. 8, 1883</b>	9. AGE (in years last birthday) <b>71</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ATTORNEY</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>REPUBLICAN CITY, NEBRASKA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>CARY SMITH</b>	13b. MOTHER'S MAIDEN NAME <b>REBECCA DREW</b>	14. NAME OF HUSBAND OR WIFE <b>BEULAH B. SMITH</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <b>MRS. BEULAH B. SMITH, 6046 SWOPE PARKWAY, KANSAS CITY, MISSOURI</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH. <b>2 wks</b>  <b>33 1/2</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertension</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)	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 **Jan 1954 to 5/7, 1954** that I last saw the deceased alive on **5/7, 1954** and that death occurred at **11:30 PM**, from the causes and on the date stated above.

23a. SIGNATURE <b>H. C. Tripp</b> (Degree or title) <b>MD</b>	23b. ADDRESS <b>1014 Apple Bldg</b>	23c. DATE SIGNED <b>5/8/54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>MAY 10, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAN CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
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DATE REC'D BY LOCAL REG. <b>5-10-54</b>	REGISTRAR'S SIGNATURE <b>Sheraldine Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Old-Newcomers Sons</b> ADDRESS <b>1351-ARCADE</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No.....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.