

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **37611****5314**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (in this place) <u>24 yrs.</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3910 E. 9th. St.</u>				STREET ADDRESS (If rural, give location) <u>19 3910 E. 9th. St.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>PAUL</u>		b. (Middle) _____		c. (Last) <u>Smith</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11 15 54</u>		
5. SEX <u>MALE</u> <input type="radio"/> <u>0</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> <u>1</u>		8. DATE OF BIRTH <u>11-6-1887</u>		
9. AGE (In years last birthday) <u>67</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FURNITURE FINISHER</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Knob Noster, Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>William Smith</u>			13b. MOTHER'S MAIDEN NAME <u>LURELLA GOUR</u>			14. NAME OF HUSBAND OR WIFE <u>ALICE SHUFORD SMITH</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>494-14-7226-A</u>		17. INFORMANT'S SIGNATURE OR NAME <u>ALICE Smith</u> ADDRESS <u>3910 E. 9th.</u>			
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) <u>Cerebrovascular</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Hypertension</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>9-14-54</u> <u>?</u> <u>?</u> <u>334X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) _____				
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? _____				
22. I hereby certify that I attended the deceased from <u>9-14</u> , 19 <u>54</u> , to <u>11-15</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>11-15</u> , 19 <u>54</u> , and that death occurred at <u>12:25</u> a.m., from the causes and on the date stated above.								
23a. SIGNATURE <u>Frank E. Day D.O.</u> (Degree or title)				23b. ADDRESS <u>4314 E 9th. K.C. Mo.</u>		23c. DATE SIGNED <u>11-16-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>11-17-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT. MORIAH</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>11-16-54</u>		REGISTRAR'S SIGNATURE <u>Neon Minshall</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Sheil FUNERAL HOME</u> ADDRESS <u>K.C. Mo.</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Frank E. Day D.O.

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.