

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20721

State File No. _____

2339

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) OR TOWN Kansas City	c. LENGTH OF STAY (in this place) 10 years	c. CITY OR TOWN Kansas City	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 General Hospital #2		STREET ADDRESS (If rural, give location) 45 3019 Terrace st.	

3. NAME OF DECEASED (Type or Print) a. (First) John	b. (Middle) Ellis	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) 5 24 1956
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-22-1900	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter	10b. KIND OF BUSINESS OR INDUSTRY Chicago Loan Company	11. BIRTHPLACE (City and State or Foreign Country) Huntsville, Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Edward Smith	13b. MOTHER'S MAIDEN NAME Maggie Seals	14. NAME OF HUSBAND OR WIFE Gussie Smith
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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. 495-10-8701	17. INFORMANT'S SIGNATURE OR NAME Gussie Smith ADDRESS 3019 Terrace st K.C. Mo.
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia, Congestive heart failure.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive heart disease. DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		443 K	

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) m.	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 5-15-56, 19 , to 5-24-56, 19 , that I last saw the deceased alive on 5-24-56, 19 , and that death occurred at 12:20 am., from the causes and on the date stated above.

23a. SIGNATURE W.R. Peters M.D.	23b. ADDRESS 600 E. 22nd St.	23c. DATE SIGNED 5-24-56
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24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 5-28-1956	24c. NAME OF CEMETERY OR CREMATORY Westlawn Cemetery	24d. LOCATION (City, town, or county) (State) Kansas City, Kansas
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DATE REC'D BY LOCAL REG. 5-28-56	REGISTRAR'S SIGNATURE Neva Marshall	25. FUNERAL DIRECTOR'S SIGNATURE Mrs. J. W. Jones ADDRESS 440 State ave.
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(Licensed Embalmer's Statement on Reverse Side)

K.C. Kansas

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

0.300
0.48

FILED JUN 25 1956

1914

NO. 10000 Date: 1914

City: State: County: District: No.:

St. Elizabeth Hospital

NAME SEX RACE OCCASION CLASS

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 *Engene English*
Licensed Embalmer No. *1410*

Licensed Embalmer No. *1410*

P. O. Address *H. C. St. L.*

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.