

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38246

State File No. _____

FILED DEC 7 - 1956

4957

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

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If location: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Kansas City,</u>		c. CITY OR TOWN <u>Kansas City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (If this place) <u>8 yrs.</u>		e. STREET ADDRESS (If rural, give location) <u>1024 West 41st.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>REV. J.</u>	b. (Middle) <u>ROY</u>	c. (Last) <u>SMITH</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>11-15-1956</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan. 7, 1906</u>	9. AGE (In years last birthday) <u>50</u>	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) <u>Minister</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Steelville Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Turner Smith</u>	13b. MOTHER'S MAIDEN NAME <u>Sibyl Clymer</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Frances R. Smith</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>494 40 5846</u>	17. INFORMANT'S SIGNATURE OR NAME, ADDRESS <u>Mrs. Frances R. Smith, 1024 West 41st.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>11-15-56</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Sub. Acute Myelogenous Leukemia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		2041	

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)	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 1, 1955, to Nov. 15, 1956, that I last saw the deceased alive on 11/14/56, 1956, and that death occurred at 8:20 m., from the causes and on the date stated above.

23a. SIGNATURE <u>Edson C. Carrier M.D.</u> (Degree or title)	23b. ADDRESS <u>2426 Plaza Mid. Bldg.</u>	23c. DATE SIGNED <u>11/16/56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>Nov. 17, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>11-16-56</u>	REGISTRAR'S SIGNATURE <u>Nevas Marshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gates Funeral Home, Kansas City, Kans.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD Edson C. Carrier

Dr. Carrier
Plaza Med. Bldg
Va-1-3434

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 *Ralph O. Groub*

Licensed Embalmer No. *5009*

P. O. Address *K.C. Key*

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.