

Health,  
& Welfare  
Public  
Service

**X** FILED JUL 30 1958

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**58-024921**

STATE FILE NUMBER

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 3293

300  
1-57

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Clay</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Excelsior Spring, Mo</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Intersection Prather &amp; Parvin Rds.</u>		d. STREET ADDRESS (If outside, give location) <u>706 N. Main</u>	

<b>3. NAME OF DECEASED</b> (Type or print) First <u>Clyde</u> Middle <u>A.</u> Last <u>Smith</u>			<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>9</u> Year <u>1958</u>		
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<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 5, 1885</u>	<b>9. AGE</b> (In years birthday) <u>73</u>	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Self employed Salesman</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Kansas</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>
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<b>13a. FATHER'S NAME</b> <u>Charles B. Smith</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Armentha Hunt</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Virginia Smith</u>
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<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>NO</u>	<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	<b>17. INFORMANT</b> <u>Mrs. Cordie Naylor, Fayette, Mo</u>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEAD &amp; CHEST INJURIES</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CAR &amp; PANEL TRUCK (VOLKSWAGEN) COLLISION</u>	
	DUE TO (c) <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u>Car &amp; Truck collision</u>
<b>20c. TIME OF INJURY</b> Hour <u>  </u> Month, Day, Year <u>7-9-58</u> a.m. <u>  </u> p.m. <u>  </u>	

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hi-way</u>	<b>20f. CITY, TOWN, OR LOCATION</b> <u>Kansas city, mo.</u>	<b>COUNTY</b> <u>Clay</u>	<b>STATE</b> <u>mo.</u>
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**21.** I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ m on the date stated above; and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <u>O.S. Pate M.D. (Coroner)</u>	<b>22b. ADDRESS</b> <u>North Kansas City, Mo.</u>	<b>22c. DATE SIGNED</b> <u>7/10/58</u>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>	<b>23b. DATE</b> <u>7-10-58</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Walnut Ridge</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>Fayette, Missouri</u>
<b>24. FUNERAL DIRECTOR</b> <u>D.W. Newcomer's Sons-No. Kansas City, Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>7-11-58</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Neva Marshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

O. S. Pate

AUG 8 1958



MAR 1958

MAR 1958

MAR 1958

AUG 10 1958

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 *Glenn H. Hill* .....

Licensed Embalmer No. *4586*

P. O. Address *K. C. 16. Mo*

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.