RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-035039
STATE FILE NUMBER

FILED VS SEP 26 1960 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4640

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: KANSAS CITY — Length of stay in 1b: 32 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: V A HOSPITAL — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: De Kalb
c. CITY OR TOWN: MAYSVILLE — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: GOLDWIN Middle: A Last: SMITH
4. DATE OF DEATH: Month September Day 9 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8-11-88
9. AGE (last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Greenhouse owner
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (City and state or country): Manistee, Mich
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Frank Smith
13b. MOTHER'S MAIDEN NAME: Myrtle Albro
14. NAME OF HUSBAND OR WIFE: Hettie T. Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 369-01-2907
17. INFORMANT: VA Hospital Official Rcds, K.C.Mo — Address: Hettie Smith, Maysville, Missouri

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from August 8, 1960, to September 9, 1960 and last saw him alive on
Death occurred at 10:05 a m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE: ROBERT M. BROWN, M.D. (Degree or title)
22b. ADDRESS: VA Hospital, Kansas City, Mo.
22c. DATE SIGNED: 9-9-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9-10-1960
23c. NAME OF CEMETERY OR CREMATORY: OAKLAWN Cem
23d. LOCATION (City, town, or county): MAYSVILLE (State): Mo
24. FUNERAL DIRECTOR: D.W. Newcomer Sons K.C. — ADDRESS
25. DATE RECD. BY LOCAL REG.: 9-10-60
26. REGISTRAR'S SIGNATURE: H. L. Dwyer

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4949

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.