

FRL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 3 1960

-60-035040

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4742

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, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in lb 16 YEARS		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3324 Virginia Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Garfield Last Smith				4. DATE OF DEATH Month 9 Day 15 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6-25-91	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months 6 Days 15 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROKER			10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (City and state or country) NEWTON, IOWA		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME AARON SMITH			13b. MOTHER'S MAIDEN NAME MARGARET E. WALKER			14. NAME OF HUSBAND OR WIFE MRS. EDNA LEE SMITH		
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. 552-28-7721		17. INFORMANT MRS. EDNA LEE SMITH			Address 3324 VIRGINIA AVE. KANSAS CITY, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Cerebellar Infarct							INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chole cystectomy							35 hrs	
DUE TO (c) Chronic Cholecystitis & Cholelithiasis							Several years	
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. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour 3:30 Month, Day, Year 9-9-60		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 9-9-60 to 9-15-60 and last saw her/him alive on 9-15-60 Death occurred at 3:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Harry C. Lapp M.D.				22b. ADDRESS 751 E 63 KC. 10mo			22c. DATE SIGNED 9-16-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE SEPT. 18, 1960	23c. NAME OF CEMETERY OR CREMATORY NEWTON UNION CEMETERY		23d. LOCATION (City, town, or county) (State) NEWTON IOWA			
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS KANSAS CITY, MO.			25. DATE RECD. BY LOCAL REG. 9-17-60		26. REGISTRAR'S SIGNATURE H-L. Dwyer			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Harry C. Lapp

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Henry E. Chenevise

Licensed Embalmer No. 4550

P. O. Address Franklin

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.