

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005535  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 628

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

AMENDED FILED VS FEB 20 1961

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>             |  | Length of stay in 1b<br><b>30 yrs.</b>   | c. CITY OR TOWN <b>Kansas City</b><br>Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                     |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>1119-B Troost</b> |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>1119-B Troost</b><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|--|--|---|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Virginia</b> Middle <b>Mae</b> Last <b>Smith</b> |  |  | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>4th</b> , Year <b>1961</b> |  |
|--|--|--|---|--|

|                      |                               |   |                                |                                       |  |  |
|----------------------|-------------------------------|---|--------------------------------|---------------------------------------|--|--|
| 5. SEX <b>Female</b> | 6. COLOR OR RACE <b>white</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <b>1/4/14</b> | 9. AGE (last birthday) <b>47 yrs.</b> | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
|----------------------|-------------------------------|---|--------------------------------|---------------------------------------|--|--|

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|---|--|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b> | 11. BIRTHPLACE (City and state or country)<br><b>Maryville, Missouri</b> | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b> |  |
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|--|--|---|--|---|--|
| 13a. FATHER'S NAME<br><b>Clark Scott</b> |  | 13b. MOTHER'S MAIDEN NAME<br><b>Nora May Linville</b> |  | 14. NAME OF HUSBAND OR WIFE<br><b>O. T. Smith</b> |  |
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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)<br><b>NO</b> |  | 17. INFORMANT Address<br><b>O. T. Smith, 1119-B Troost Ave.</b> |  |  |  |
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|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure &amp; deepening</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>20-30 min</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Cerebral artery of neck</b>                                |  |  | <b>6 MO</b>  |
| DUE TO (c) <b>Subarachnoid cell carcinoma</b>  |  |  | <b>3 MO</b>  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 19. WAS AUTOPSY PERFORMED?<br>YES <input 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.) |  |  |  |
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|  |                  |  |  |        |       |
|--|------------------|--|--|--------|-------|
| 20c. TIME OF INJURY<br>Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.  | Month, Day, Year | 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 <b>Dec 1-60</b> to <b>Feb 4-61</b> and last saw her <b>live on 2-1-61</b><br>Death occurred at <b>8:30 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |                                   |  |
| 22a. SIGNATURE<br><b>John T. Skinner MD</b>   |  | 22b. ADDRESS<br><b>1102 Grand St. EMO</b> |  | 22c. DATE SIGNED<br><b>2-5-61</b> |  |

|  |                            |  |   |  |  |
|--|----------------------------|--|---|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>2/6/61</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FOREST HILL</b> | 23d. LOCATION (City, town, or county) (State)<br><b>Kansas City MO.</b> |  |  |
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| 24. FUNERAL DIRECTOR ADDRESS<br><b>Muehlebach Funeral Home, 6800 Troost</b> |  | 25. DATE RECD. BY LOCAL REG.<br><b>2-6-61</b> | 26. REGISTRAR'S SIGNATURE<br><b>Ruth Long</b> |  |  |
|---|--|---|---|--|--|

DOCUMENT

BY AFFIDAVIT OF **John T. Skinner, M.D.** MEDICAL CERTIFICATION

ONE NIS HOME MEMORIAL 3 1966  
De 3-1566

**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 R. E. Nichols

Licensed Embalmer No. 4997

P. O. Address R. E. Nichols

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.