

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-011367
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1268

FILED MAR 26 1962

VS 300
Rev. 4/59

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DATE AMENDED

3-6-62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

Anna Smith

ITEM NO. SHOULD READ

13b Anna Meyers

DOCUMENT

BY AFFIDAVIT OF

H. Owens MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in 1b <u>77 YRS.</u>	c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O. A. OSTEOPATHIC Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>707 PASEO</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>E.D. SMITH</u>			4. DATE OF DEATH Month Day Year <u>MARCH 2, 1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR <u>4-5-1878</u> <u>83 YRS.</u> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED RESTAURANT OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RESTURANT</u>	11. BIRTHPLACE (City and state or country) <u>LOUISVILLE KENTUCKY</u>
13a. FATHER'S NAME <u>JACOB SMITH</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA SMITH MEYERS</u>	14. NAME OF HUSBAND OR WIFE <u>CLAIRE SMITH</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>MRS. ARTHUR MIKNER</u> Address <u>SUGAR CREEK MO.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Hugh Owens Owens</u>		22b. ADDRESS <u>159 Union Station</u>	22c. DATE SIGNED <u>3-26-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3-5-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>
24. FUNERAL DIRECTOR <u>MUEHLEBACH</u>		25. DATE RECD. BY LOCAL REG. <u>3-3-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
23d. LOCATION (City, town, or county) <u>KANSAS CITY, MO.</u>			

USE BLACK INK OR TYPEWRITER RIBBON

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DR. OWENS.

10-1 UNION SPAT.

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 K. C. - 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.