

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

6271 **63-044279**
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6271

FILED DEC - 2 1963

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>20 YEARS</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>DEAD ON ARRIVAL K.C. GENERAL HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2919 MICHIGAN AVENUE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>EVERETT EDWARD SMITH</u>			4. DATE OF DEATH Month Day Year <u>NOVEMBER 15 1963</u>		
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/11/1893</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ORDERLY</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>VET. ADMIN. HOSPITAL</u>	11. BIRTHPLACE (City and state or country) <u>COBYS, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>AUGUST SMITH</u>	13b. MOTHER'S MAIDEN NAME <u>MINNIE GRIMMEL</u>	14. NAME OF HUSBAND OR WIFE <u>MRS. MABEL L. SMITH</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WORLD WAR I</u>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>MRS. MABEL L. SMITH, 2919 MICHIGAN AVENUE, KANSAS CITY, MO</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), (c), (d), (e).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> 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

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.)
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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
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at 10:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree or title) <u>[Signature]</u>	21b. ADDRESS <u>6671 Prospect St, Overland Park, Mo</u>	21c. DATE SIGNED <u>11-15-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>NOV. 20, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>FORT LEAVENWORTH KANSAS</u>
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24. FUNERAL DIRECTOR <u>D.W. NEWMOMER'S SONS</u> ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>11-18-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>
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(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

1
2 3408
3
4 0
5 1
6
7 0
8 2
942.00
10
11
1292-3
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF C. Kealhofer MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

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

Rosal A. Boye

Licensed Embalmer No. 4892

P. O. Address OVERLAND PARK, KS

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.