WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Dunklin

Township Salem

or Village ~~Near Bussola~~

or City _____ (NO. _____ St.: _____ Ward)

Registration District No. 290 File No. 4465

Primary Registration District No. 5408 Registered No. 13

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME George H Smith

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Oct (Month) 15 (Day), 1857 (Year)

AGE: 56 yrs. 3 mos. 19 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer 1
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer 12 10

BIRTHPLACE (City or town, State or foreign country): Tennessee

PARENTS

NAME OF FATHER: Simon Smith

BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn

MAIDEN NAME OF MOTHER: Fannie Smith 8

BIRTHPLACE OF MOTHER (City or town, State or foreign country): not known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

X (Informant) Brown Smith

X A Fore (ADDRESS) Byrds Mo

Filed 2/4, 1914. W E Handley REGISTRAR

MEDICAL CERTIFICATE OF DEATH 3

DATE OF DEATH: Feb. (Month) 3 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 27, 1914, to Feb 3, 1914, that I last saw him alive on Feb 3", 1914, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Sequel of Typhoid Fever which Superinduced Lobular Pneumonia = Acute Peritonitis

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W H Russell M. D.

_____, 191__ (Address) Byrds Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: McGrew County

DATE OF BURIAL: 2/5, 1914

UNDERTAKER: C P McDaniel

ADDRESS: Smith Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), 1__ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), 191__ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191__
UNDERTAKER	ADDRESS