

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.

PLACE OF DEATH

County Pettis

Township _____

or _____

Village Smithton

or _____

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

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 669 File No. 7100Primary Registration District No. 3892 Registered No. 8

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

FULL NAME

Minor S. Combs

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>
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DATE OF BIRTH <u>March 23, 1844</u>	(Month) (Day) (Year)
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AGE <u>72</u> yrs. <u>10</u> mos. <u>28</u> ds.	IF LESS than 1 day, _____ hrs. or _____ min.?
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OCCUPATION
(a) Trade, profession, or particular kind of work merchant
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) Mo

PARENTS	NAME OF FATHER <u>Feilding Combs</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ky</u>
	MAIDEN NAME OF MOTHER <u>Mary McK</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ky</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel Combs(ADDRESS) Nevada Mo

Filed Feb 25, 1917 S. M. Parnell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 21, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Feb 11, 1917, to Feb 21, 1917, that I last saw him alive on Feb 21, 1917, and that death occurred, on the date stated above, at 49 m. The CAUSE OF DEATH* was as follows:
Arterio Sclerosis

97 (Duration) 81 yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. 10 ds.
(Signed) S. M. Parnell M. D.
Feb 25, 1917 (Address) Smithton 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 <u>Smithton Cemetery</u>	DATE OF BURIAL <u>Feb 22, 1917</u>
UNDERTAKER <u>Newmeyer</u>	ADDRESS <u>Smithton</u>

PLACE OF DEATH

County

Township

or

Village

or

City

Registration District No.

Primary Registration District No.

(NO.

File No.

Registered 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) (Year)	(If LESS than 1 day, hrs. or min. ?)
AGE	(Month) (Day) (Year)	(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)

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

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

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.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) (Day) (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)

(Address) M. D.

*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