LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

Dr Roy

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

1 PLACE OF DEATH

County: Shelby

Township or Village or City: Clarence

Registration District No.: 560 File No.: 3913

Primary Registration District No.: 6064 Registered No.:

(NO. ..... St.: ..... Ward)

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

2 FULL NAME Sarah E Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Oct 6 1841 (Month) (Day) (Year)

7 AGE: 76 yrs. 3 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry business, or establishment in which employed (or employer): —

9 BIRTHPLACE (City or town, State or foreign country): K. Y.

PARENTS

10 NAME OF FATHER: John Hounsldick

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): K. Y.

12 MAIDEN NAME OF MOTHER: Elizabeth Mitchell

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): K. Y.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Kennie Smith
(Address): Clarence Mo

15 Filed: Feb. 13, 1918 J. G. Hyatt, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. 4, 1918 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191..., to ....., 191..., that I last saw her alive on Jan. 1, 1918, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

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

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank R. Roy M. D.

Jan 3, 1918 (Address) Clarence, Mo.

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Union

DATE OF BURIAL: 2-6-1918

20 UNDERTAKER: E E Hopper

ADDRESS: Clarence

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 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 o
hospital or
give its NA
of street an

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

.....yrs. ..... mos. ..... ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 1

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and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. ..... mos. .....

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. ..... mos. .....

(Signed) .....

....., 191..... (Address) .....

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19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIA

20 UNDERTAKER	ADDRESS