LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County: Jasper

Township or Village or City: Webb City

Registration District No.: 417

Primary Registration District No.: 3021

File No.: 34225

Registered No.: 775

NO. Jasper Co Tuberculosis Hospital (Ward)

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

2 FULL NAME: L. A. Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: unknown (Month) (Day), 1 (Year)

7 AGE: About 45 yrs ... yrs. ... mos. ... ds.

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

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

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

PARENTS

10 NAME OF FATHER: unknown

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

12 MAIDEN NAME OF MOTHER: unknown

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): O. A. Rice

(Address): Carterville, Mo.

15 Filed: Oct 24, 1918. C. E. McBride, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 23 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 23, 1918 to Oct 23, 1918, that I last saw him alive on Oct 22, 1918, and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

230 Pul Tuberculosis

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

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

(Signed) Geo A Stock M. D.

Oct 23, 1918 (Address) Webb City 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. 1 mos. — ds. In the State 41 yrs. ... mos. ... ds.

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

Former or usual residence: Webb City Mo

19 PLACE OF BURIAL OR REMOVAL: Mt Hope Cem

DATE OF BURIAL: Oct 24, 1918

20 UNDERTAKER: Steele and Co

ADDRESS: Webb City Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
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 occurred in a hospital or institution, give its NAME instead of street and number.]

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
....., 191.....
(Month) (Day) (Year)

17 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.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....dys. 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	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

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.