

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

1 PLACE OF DEATH
County Ralls
Township Sanerton
OR
Village Blasco
OR
City _____ (NO _____ St. _____ Ward _____)

Registration District No. 729 File No. 14894
Primary Registration District No. 5357 Registered No. 14120

2 FULL NAME William E. Smith

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

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>Mar 16</u> 18 <u>52</u> (Month) (Day) (Year)		
7 AGE <u>67 yrs 1 mos 4 ds.</u>		If LESS than 1 day, ____ hrs. or ____ min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Restaurant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>keeper</u>		
9 BIRTHPLACE (City or town, State or foreign country) <u>Indiana</u>		
PARENTS	10 NAME OF FATHER <u>J V Smith</u>	
	11 BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ky.</u>	
	12 MAIDEN NAME OF MOTHER <u>Eleabeth Vester</u>	
	13 BIRTHPLACE OF MOTHER <u>not known</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ada Smith
(Address) Blasco Mo

15 Filed 4/28 1919
6-12-1919 Registrar

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH <u>April 20</u> 19 <u>19</u> (Month) (Day) (Year)	
17 I HEREBY CERTIFY, that I attended deceased from <u>April 20</u> 19 <u>19</u> to <u>April 20</u> 19 <u>19</u> that I last saw him alive on <u>April 20</u> 19 <u>19</u> and that death occurred, on the date stated above, at <u>2:30</u> p.m. The CAUSE OF DEATH* was as follows: <u>Apoplexy</u> <u>82A</u> <u>64</u> (Duration) ____ yrs ____ mos ____ ds.	
CONTRIBUTORY (Secondary) _____ (Duration) ____ yrs ____ mos ____ ds.	
(Signed) <u>J B Chittam</u> M. D. <u>April 22, 1919</u> (Address) <u>Harvard</u>	
*State the Disease Causing Death, or, in death 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 <u>Int Union</u>	DATE OF BURIAL <u>April 22, 1919</u>
20 UNDERTAKER <u>Wm M Smith</u>	ADDRESS <u>Harvard</u>

1 PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE 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 hospital or give its NAME of street and

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) 1 (Day) 1 (Year)
 7 AGE yrs. mos. ds. If LESS than 1 day, ... hrs. 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)

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

Filled 191 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (Month) 18 (Day)

17 I HEREBY CERTIFY, that I attended deceased 191 to that I last saw him alive on 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)

*State the Disease Causing Death, or, in death from Violent Cause (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.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS