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

1 PLACE OF DEATH

County St. Louis

Township Bonhomme
or
Village Bellefontain
or
City ..... (NO. ..... St.: ..... Ward)

Registration District No. 785 File No. 23245

Primary Registration District No. 6031 Registered No. 84

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

2 FULL NAME Lucy Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH April (Month) 30th (Day) 1836 (Year)

7 AGE 83 yrs. 2 mos. 21 ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry business, or establishment in which employed (or employer) house keeping

9 BIRTHPLACE (City or town, State or foreign country) St Louis Co. Missouri

PARENTS

10 NAME OF FATHER George Smith

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) St Louis Co. Missouri

12 MAIDEN NAME OF MOTHER Sophie Nichokon Sharp

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Nichols Co. Kentucky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ora G. Smith

(Address) Chesterfield, Mo.

15 Filed 7/24, 1919 C A Dunnavant Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 21st (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 7th, 1919, to July 21, 1919, that I last saw her alive on July 21, 1919, and that death occurred, on the date stated above, at 12:15 P.m.

The CAUSE OF DEATH* was as follows:

8 VA Apoplexy
16 V

64

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Age

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

(Signed) J. L. DeFoe M. D.

July 21, 1919 (Address) Chesterfield 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 Bonhomme Cemetery

DATE OF BURIAL July 22 1919

20 UNDERTAKER Wm. Schrader

ADDRESS Ballwin Mo.

MISSOURI STATE BOARD C
BUREAU OF VITAL STATIS
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)

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) .....(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) .....(D

17 I HEREBY CERTIFY, that I attended .....191....., to.....
that I last saw h.....alive on.....
and that death occurred, on the date stated above.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
.....(Duration).....yrs.
CONTRIBUTORY .....
(Secondary)
.....(Duration).....yrs.
(Signed).....
....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Viol (1) Means of Injury; and (2) whether Accidental, Suicide,

18 LENGTH OF RESIDENCE (For Hospitals, Institutio or Recent Residents)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF B**

20 UNDERTAKER | **ADDRESS**

Medical Association.

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: "*Farmer (retired, 6 yrs.)*" For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria*