LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH
County Laclede — Registration District No. 448 — File No. 34
Township Union — Primary Registration District No. 6608 — Registered No. 34
City ..... (No. ..... St. ..... Ward)

2. FULL NAME John W. Smith
(a) Residence No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Lizzie Freshour

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE: 53 Years — Months: Dont — Days: Know — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Green Co, Tenn

PARENTS
10. NAME OF FATHER: Sam Smith
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): East Tenn.
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): East Tenn.

14. INFORMANT (Address): J. S. Freshour, Conway, Mo

15. FILED 6-10, 1920 O. C. Benage REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 30 — 1920

17. I HEREBY CERTIFY, That I attended deceased from Feb 10th, 1920, to May 30 — 1920 that I last saw him alive on Mar 9th, 1920, and that death occurred, on the date stated above, at 9 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23A
..... (duration) ..... yrs. 18 mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) O. C. Benage, M. D
6-4, 1920 (Address) Conway, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Radu Cemetery — DATE OF BURIAL: 6-2-1920

20. UNDERTAKER: H. Moffitt — ADDRESS: Conway Mo

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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

19799 D

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

1. PLACE OF DEATH
County: Laclede — Registration District No.: 448 — File No.: 2
Township: Union — Primary Registration District No.: 5608 — Registered No.: 2
City: ..... (No. ..... St. ..... Ward)

2. FULL NAME: John Benjamin Daniels
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan. 28-1853

7. AGE: 67 YEARS — MONTHS: 4 — DAYS: 28 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio

PARENTS
10. NAME OF FATHER: Mashek Daniels
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio
12. MAIDEN NAME OF MOTHER: Ant Knox
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio

14. INFORMANT (Address): Nannie A. Johnston, Conway, Mo

15. FILED 6-25-1920 D. C. Benage, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 21 1920

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1920, to June 20, 1920 that I last saw him alive on June 20, 1920, and that death occurred, on the date stated above, at 11 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Progressive Muscular Atrophy
..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) T. A. Gourley, M. D
6-22, 1920 (Address) Phillipsburg, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Phillipsburg Cemetery — DATE OF BURIAL: 6-22-1920

20. UNDERTAKER: B. F. McFarland — ADDRESS: Phillipsburg

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.