CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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

PLACE OF DEATH

County Wright

Township ~~Montain Gr~~

or Village

or City Montain Gr (NO. 418 Third St.; Ward)

Registration District No. 908 File No. 3127

Primary Registration District No. 4549 Registered No. 128

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

FULL NAME Virgil Clifton Smith

PERSONAL AND STATISTICAL PARTICULARS

SEX male

COLOR OR RACE white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Child

DATE OF BIRTH March 5 1920 (Month) (Day) (Year)

AGE ..... yrs. 10 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION (a) Trade, profession, or particular kind of work 0 0 107

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0 136

BIRTHPLACE (City or town, State or foreign country) Plato Texas Co Missouri

PARENTS

NAME OF FATHER E. W. Smith

BIRTHPLACE OF FATHER (City or town, State or foreign country) Herington Dickenson Co. Kansas

MAIDEN NAME OF MOTHER Cleta Farrah

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Plato Texas Co Mo Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. H. Fancher

(ADDRESS) Mt Grove Mo

Filed 2/4 1921 J. M. Hubbard REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 25 (Month) (Day) 1921 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan-16, 1921, to Jan-25, 1921 that I last saw him alive on Jan 25, 1921, and that death occurred, on the date stated above, at 9 57 a.m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis - Broncho Pneumonia

Bronchitis (Duration) 100 yrs. ..... mos. 5 ds.

Contributory (SECONDARY) Broncho-Pneumonia (Duration) ..... yrs. ..... mos. 9 ds.

(Signed) Edward J. C. Wittmer M. D.

Jan-25 1921 (Address) Mtn Grove Mo

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

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

PLACE OF BURIAL OR REMOVAL New Cuty

DATE OF BURIAL Jan 26 1921

UNDERTAKER N L Butler

ADDRESS Montain Gr

Exact statement of OCCUPATION is very important.

Revised United States Standard

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-*

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

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]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

..... (Month) ..... (Day) ..... (Year)

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

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

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

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

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

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

RE

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

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

I HEREBY CERTIFY, that I attended deceased fro

....., 191..., to ....., 191...

that I last saw h..... alive on ....., 191...

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory (SECONDARY) .....

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

(Signed) ..... M.

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, 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 .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191...
UNDERTAKER	ADDRESS