LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

28039

PLACE OF DEATH
County: Texas — Registration District No.: 863 — File No.:
Township: Piney — Primary Registration District No.: 6137 — Registered No.: 421
City: Houston (No. ..... St. ..... Ward)

FULL NAME: Jesse Franklin Smith

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Widowed

6. IF MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) ~~WIFE OF~~: Susie Smith

7. DATE OF BIRTH (MONTH, DAY AND YEAR): May 28 1851

8. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	3	4	

9. 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:

10. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Texas

11. NAME OF FATHER: Jesse R. Smith

12. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

13. MAIDEN NAME OF MOTHER: Elizabeth Elmore

14. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Virginia

15. INFORMANT: Emma Frank
(Address): Houston Mo

FILED 9-5 1924 — J. W. Nowacek, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 2 1924

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 1924 to Sept 3 1924 that I last saw him alive on Sept 1 1924 and that death occurred, on the date stated above, at 1:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Asphyxia
Hanged
(duration) ..... yrs. ..... mos. 22 ds.

CONTRIBUTORY (SECONDARY): Mania
(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) J. M. Plummer, M. D.
, 19 (Address) Houston 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	DATE OF BURIAL
Houston Cemetery	Sept 5 1924
20. UNDERTAKER: Gayland V. Elliott	ADDRESS: Cabool

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....W

2. FULL NAME .....

(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

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

(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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

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I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 1
that I last saw h..... alive on....., 19....., a
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURI
20. UNDERTAKER	ADDRESS