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

6796

1 PLACE OF DEATH

County Barry

Township White River Registration District No. 38 File No. 2

or

Village Primary Registration District No. 5054 Registered No.

or

City (NO. St.; Ward)

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

2 FULL NAME Eleanor Baird Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

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

6 DATE OF BIRTH Sep (Month) 7 (Day), 1838 (Year)

7 AGE 86 yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or ...min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work teaching school
(b) General nature of industry business or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Mount Perry Perry Co Ohio

PARENTS

10 NAME OF FATHER Samuel Baird

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

12 MAIDEN NAME OF MOTHER Betannie Huston

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Fannies

(Address) Grandview Ark

15

Filed March 26 1925 Emma Weddington Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March Mar (Month) 18 (Day), 1925 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..., 191..., to ..., 191...,

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

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

The CAUSE OF DEATH* was as follows:

Paralysis

S.S.D

(Duration) 15 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

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

(Signed) Lident Lane Dr M. D.

..., 191... (Address)

*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 DATE OF BURIAL March 19, 1925

20 UNDERTAKER ADDRESS

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

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

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

City ..... (NO. ....., ..... St.; ..... Ward)

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

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), 1..... (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) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

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

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

CONTRIBUTORY .....
(Secondary)

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

(Signed) .....M. D.

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

*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

DATE OF BURIAL ....., 191.....

20 UNDERTAKER

ADDRESS