

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

Do not use this space.

8297

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City..... **St. Louis** (No. **1620** **Carver** St.)

File No. **1478**
Registered No.
St. Ward)

2. FULL NAME

Henry Smith
(a) Residence. No. **1620** **Carver** St., **15** 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 W. C.	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Callie Smith		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12/13/1873		
7. AGE YEARS 53	MONTHS 1	DAYS 26
if LESS than 1 day, _____ hrs. or _____ min.		

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

9. BIRTHPLACE (CITY OR TOWN) **Macos**
(STATE OR COUNTRY) **Ala.**

10. NAME OF FATHER **Henry Smith**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Tenn.**
12. MAIDEN NAME OF MOTHER **Unknown**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **1**

14. INFORMANT **H. W. Dax**
(Address) **Commission Office**

15. FILED **FEB 12 1927**
19. **Max B. Starckoff**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **2/8 1927**
17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at **8-30 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
M.M.C. (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) **90A** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
8. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY? **Yes**
WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) **H. W. Dax** M.D.
2/10 1927 (Address) **Deputy Coroner**

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **St. Peters. Cementary** DATE OF BURIAL **2/13 1927**
20. UNDERTAKER **W.C. Gordon Und. Co.** ADDRESS **2649 Morgan St.**

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.

THIS IS A PERMANENT RECORD

