

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

Do not use this space.

8176

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 1020
 Township Kaw Primary Registration District No. 1005 Registered No. 1020
 City Manassas City (No. Murain Hospital) St. _____ Ward _____

2. FULL NAME

John Samuel Smith
 (a) Residence, No. Caney Kansas 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. 4 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July-20-185</u>		
7. AGE	YEARS	MONTHS
	<u>75</u>	<u>7</u>
		DAYS
		<u>18</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Glass Blower</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Factory</u>		
(c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Ky.

10. NAME OF FATHER unknown Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) no record

12. MAIDEN NAME OF MOTHER no record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) no record

14. INFORMANT Wm. Dennis Brady
 (Address) 3415 Summit

15. FILED Mar 10 27 1927 M. M. Brown
 Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March-8-1927

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1927, to Mar 8, 1927, that I last saw him alive on Mar 8, 1927, and that death occurred, on the date stated above, at 6:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Hemorrhage
74a1 (duration) yrs. mos. 20 da.
 CONTRIBUTORY Arteriosclerosis
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical examination

(Signed) J. H. Stike, M. D.
 3/9/27 (Address) 416 Collins Bldg., N. C. 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Coffeyville, KS DATE OF BURIAL Mar-10, 1927

20. UNDERTAKER Mrs. E. L. Foster ADDRESS K. C. 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.

PERMANENT RECORD

