

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

Do not use this space.

9230

APR 27 1927

1. PLACE OF DEATH

County Pike
Township Pena
City

Registration District No. 688
Primary Registration District No. 5916

File No.
Registered No. 4
St. Ward

2. FULL NAME

(a) Residence. No. St. Ward Hannibal Mo.
(Usual place of abode) (if nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 3 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 7 - 1872

7. AGE YEARS MONTHS DAYS IF LESS than I day, hrs. or min.
54 10 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farm Work
(b) General nature of industry, business, or establishment in which employed (or employer) " "
(c) Name of employer Harry Stewart

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Co. Mo

PARENTS

10. NAME OF FATHER Marion J. Smith

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

12. MAIDEN NAME OF MOTHER Katherine Simpson

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

14. INFORMANT Katherine Smith (Address) Hannibal Mo.

15. FILED March 30 1927 Mattie Russell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 30, 1927

17. I HEREBY CERTIFY, That I attended deceased from March 28, 1927, to March 30, 1927, that I last saw him alive on March 28, 1927, and that death occurred, on the date stated above, at 9 a.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1. Pneumonia Heart Disease

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) O. W. Burdgress, M. D.

March 30, 1927 (Address) Frankford, 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 DATE OF BURIAL

Hannibal Mo. 3/30 - 1927

20. UNDERTAKER ADDRESS

Schwartz Funeral Home Hannibal 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.

MAISON
v of KK

2021

Bellevue Hospital
NY State Psychiatric Institute

Dr. H. H. ...
NYC 100

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Pike Registration District No. 688 File No. _____
 Township peno Primary Registration District No. 2916 Registered No. 4
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME William P. Pruitt
 (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. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 30 19 27

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

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____, 19____, and that death occurred, on the date _____, at _____.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Organic heart disease
Coronary heart lesion
 (duration) _____ yrs. _____ mos. _____ ds.

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

CONTRIBUTORY (SECONDARY) 9000
 (duration) _____ yrs. _____ mos. _____ ds.

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 _____

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

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

10. NAME OF FATHER _____

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) W. J. Zins, M. D.
 , 19____ (Address) Franklin, Mo.

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

12. MAIDEN NAME OF MOTHER _____

*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.)

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

14. INFORMANT _____
 (Address) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

15. FILE NO. Me 30 19 27 Mattie Unsell
 REGISTRAR

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY STATUTE. Every copy of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of date of death should be given in plain terms, so that it may be properly classified.

SUPPLEMENTARY

S-9230