

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

Do not use this space.

13771

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis,*

(No. *St. Johns Hospital*)

File No.....

Registered No. *4121*

St.....

Ward.....

2. FULL NAME

Ira Smith

(a) Residence, No. *Miami, Okla* St., *12* Ward. *Miami Okla*
(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

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

Nancy Smith

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

Nov. 27 - 1876

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

50

5

3

8. OCCUPATION OF DECEASED

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

Medical

(b) General nature of industry, business, or establishment in which employed (or employer)

Doctor

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ark.

10. NAME OF FATHER

Louis P. Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Miss.

12. MAIDEN NAME OF MOTHER

Don't Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Don't Know

14.

INFORMANT

(Address)

*J. C. Smith
3703 Washington*

15.

MAY - 1 1927
FILED

Max C. Starckoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.

I HEREBY CERTIFY That I attended deceased from *3-27*, 19*27*, to *4-30*, 19*27* that I last saw him alive on *4-30*, 19*27*, and that death occurred, on the date stated above, at *7:30 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*respiritis Parenchymatosa
chronica
131*

CONTRIBUTOR (SECONDARY)

1290

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

Miami Oklahoma

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?

lab

(Signed)

Rayson Cawell, M.D.

May 1, 1927 (Address)

550 Century Bldg

*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

Miami, Okla

5-2-1927

20. UNDERTAKER

ADDRESS

Wagoner

3621 Olive

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.

