

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

Do not use this space.

1927

1. PLACE OF DEATH

County Gasconade
Township Maple
City Maple (No.)

Registration District No. 411
Primary Registration District No. 2002

File No. 27546
Registered No. 438
St. Ward)

2. FULL NAME

(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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10-1-1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 2 10

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Pickens Okla.
(STATE OR COUNTRY)

10. NAME OF FATHER Earl Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) mo.
(STATE OR COUNTRY) Hayes Norwell

12. MAIDEN NAME OF MOTHER mo. //

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

14. INFORMANT Earl Smith
(Address)

15. FILED 9/7 19 27 A. B. Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-8-1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1927, to Sept 7, 1927, that I last saw him alive on Sept 7, 1927, and that death occurred, on the date stated above, at 4:38 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

119B
1131B
119B (duration) yrs. mos. ds. 14 ds.
CONTRIBUTORY (SECONDARY) 1131B
(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?

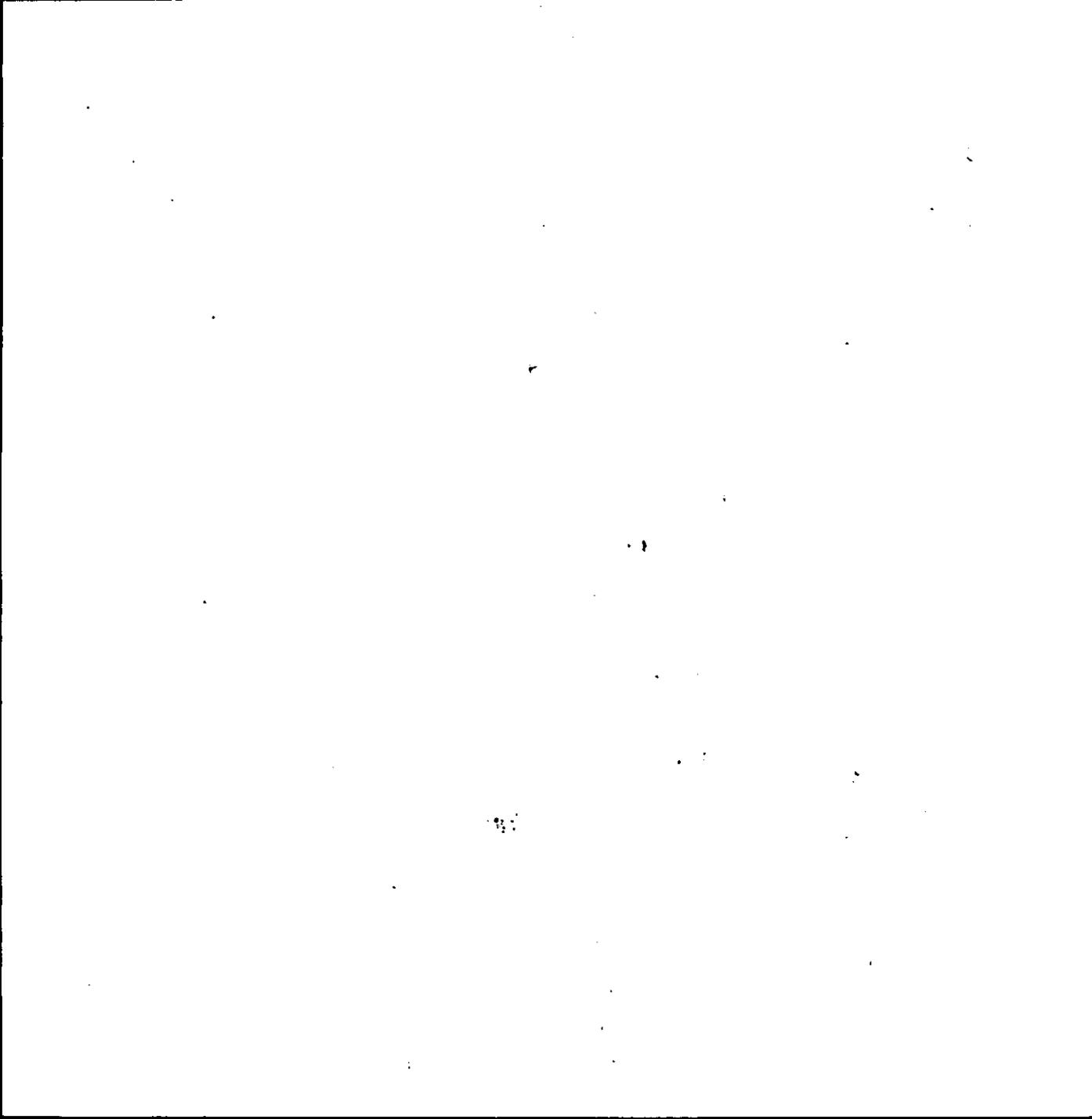
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Des. Elsworth M. D.
, 19 (Address) Maple 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 Cartersville mo DATE OF BURIAL 9-9-1927

20. UNDERTAKER M. W. Green ADDRESS Pickens Okla.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Jasper Registration District No. 411 File No. _____
 Township _____ Primary Registration District No. 2902 Registered No. 424
 City Joplin (No. _____) St. _____ Ward _____

2. FULL NAME Howard Leroy Smith
 (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

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
 (Specify the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-27-26
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 2 11
 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 _____
 9. BIRTHPLACE (CITY OR TOWN) Picher, Okla (STATE OR COUNTRY)
 10. NAME OF FATHER Carl Smith
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Angela Worrel
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY)
 14. INFORMANT Carl Smith (Address)
 15. FILED 11/14/27 Wenson Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-8-27
 17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
 _____ (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.
 18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19____ (Address)
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____
 20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

RECEIVED CHARGE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 EXACTLY as prescribed by law
 CAUSE OF DEATH should be carefully classified according to the International Classification of Causes of Death, 10th Revision, 1989

MEMORANDUM FOR THE DIRECTOR

DATE: 10-10-54

TO: THE DIRECTOR

FROM: [Illegible]

SUBJECT: [Illegible]

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MISSOURI STATE BOARD OF EXAMINERS
BOARD OF ALIEN EXAMINERS