

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

Do not use this space.

28374

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1008**

City **St. Louis Mo.** (No. **1211 Hickory St.**)

File No. **7892**

Registered No.

St. Ward

2. FULL NAME

Hazel Smith

(a) Residence. No. **1211 Hickory** St., **22** 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

female

4. COLOR OR RACE

white

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

infant

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

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

Oct 23-1926

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

10

12

8. OCCUPATION OF DECEASED

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

nile

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

Lloyd E. Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Clara Rowland

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14.

INFORMANT (Address)

*Mr. Lloyd E. Smith
1211 Hickory St.*

15.

FILED

SEP - 5 1927

*Max B. Harkesoff
REGISTRAR*

MEDICAL CERTIFICATE OF DEATH

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

Sept 4 1927

17.

I HEREBY CERTIFY, That I attended deceased from *Sept 3rd*, 1927, to *Sept 4*, 1927, that I last saw him alive on *sep 4*, 1927, and that death occurred, on the date stated above, at *sep 4*, 4 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diarrhea and Enteritis

119 B 1130 (duration) yrs. mos. *14* ds.

CONTRIBUTORY (SECONDARY)

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) *D. T. Blank*, M. D.

, 19 (Address) *1348 Chouteau Ave*

*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

Bunker Mo

Sept 6 1927

20. UNDERTAKER

ADDRESS

E. J. Schmur

3125 Lafayette

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.

