26 1927

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

Do not use this space.

31009

1. PLACE OF DEATH
County Monroe — Registration District No. 581 — File No.
Township — Primary Registration District No. 4343 — Registered No. 34
City Monroe City (No. ..... St. ..... Ward)

2. FULL NAME Lawrence Edward 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 10-1927

7. AGE: Years 1 — Months 2 — Days 23 — If LESS than 1 day, ... hrs. or ..... min.

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) Monroe City
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Barney Smith
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kendell
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Olivia Lawrence
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Indian Creek
(STATE OR COUNTRY) Missouri

14. INFORMANT Barney Smith
(Address) Monroe City Mo

15. FILED 10/4, 1927. O. W. Wilson, Registrar, Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 3rd 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1927, to October 3, 1927 that I last saw him alive on October 3, 1927, and that death occurred, on the date stated above, at 5:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Tuberculous Meningitis
24A
(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (SECONDARY) 32A
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Not known
DID AN OPERATION PRECEDE DEATH? no. DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Physical Findings
(Signed) John H Kibbe, M.D
10/4, 1927 (Address) Monroe City 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: St Under Cemetery — DATE OF BURIAL: Oct 5th 1927

20. UNDERTAKER: Wilson & Son — ADDRESS: Monroe City Mo

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: Monroe — Registration District No.: 581 — File No.:

Township: — Primary Registration District No.: 4343 — Registered No.: 34

City: Monroe City (No. ..., ... St. ... Ward)

2. FULL NAME: Lawrence Edward Smith

(a) Residence. No. ... (Usual place of abode) St., ... Ward. ... (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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 11th 1926

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
	1	2	23	

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)

(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT

(Address)

15. FILED 12/10, 1927 O.W. Wilson Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 3 — 1927

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

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) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly coded. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH

5-31009