

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

Do not use this space.

32724

1. PLACE OF DEATH

County Buchanan
Township.....
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001
(No. Missouri Methodist Hospital)

File No.....
Registered No. 1109
St. Ward)

2. FULL NAME Catherine Smith

(a) Residence. No. County Poor Farm St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 7 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1871 Nov 11

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
About 56 Unknown

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

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) France

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Records County Poor Farm
(Address) St. Joseph, Mo.

15. FILED NOV 4 1927
John G. [Signature]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1927 to Nov 3rd 1927, and that I last saw her alive on Nov 3rd 1927, and that death occurred, on the date stated above, at 8/15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Endocarditis chronic

CONTRIBUTORY Thrombus left femoral artery
(SECONDARY) of gangrene left limb
(duration) yrs. mos. da. 20

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

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) A. E. Holley M. D.

Nov. 4, 1927 (Address) 822 Edmond St. Joseph, 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 Mount Olivet Cemetery DATE OF BURIAL Nov. 5, 1927

20. UNDERTAKER H. C. Siderofader ADDRESS 1302 Union Str.

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.

1928

