

1928

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

Do not use this space.
32842

1. PLACE OF DEATH
County Washington Registration District No. 86
Township Washington Primary Registration District No. 15127
City St Joseph (No. County Farm) St. _____ Ward _____
2. FULL NAME John D. Smithers
(a) Residence, No. _____ St. _____ Ward Oregon, Mo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 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 wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 | x | x
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer No

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Unknown
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Unknown

14. INFORMANT Supr C. Farm
St Joseph Mo
15. FILED 22 1927
J. D. Baustake
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 15 1927
17. I HEREBY CERTIFY That I attended deceased from the Aug 10th 1927, to Nov 14th 1927, that I last saw h. him alive on Nov 14th 1927, and that death occurred, on the date stated above, at 3:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio Sclerosis
Hypostatic Pneumonia
CONTRIBUTORY (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
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) Albert E. Holley, M. D.
11/22 1927 (Address) 822 Edmund 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 Gly Cem DATE OF BURIAL 11/23 1927
20. UNDERTAKER J. D. Baustake ADDRESS 216 So
St Joseph Mo 1524

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.

PERMANENT RECORD

CAUSE OF DEATH in plain terms, so that it may be readily understood. A full and complete history should be carefully applied. The physician should state the cause of death in plain terms, so that it may be readily understood.

W. H. Kelly

*W. H. Kelly
822
St. Paul*

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

ALL INFORMATION REQUESTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Buchanan Registration District No. 86 File No. _____
 Township Washington Primary Registration District No. 5127 Registered No. 68
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME John D. Smithers
 (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 _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

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

7. AGE	YEARS	MONTHS	DAYS	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) _____
 (STATE OR COUNTRY) _____

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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 15 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____, 19____, and that death occurred, on the date stated above, at _____, Mo.)

THE CAUSE OF DEATH WAS AS FOLLOWS:
Atypical Sclerosis
Broncho-Pneumonia
 (duration) _____ yrs. mos. ds.
 CONTRIBUTOR (SECONDARY) Hypostatic pneumonia
 (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.

14. INFORMANT _____ (Address) _____

15. FILE NO. 12-9-27 J. Bausch REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

PERMANENT EXPIRES
 AGE 100
 CAUSE OF DEATH
 REGISTERARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-32842