FEB 20 1928

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

Do not use this space.

624

1. PLACE OF DEATH
County Dent
Township W Springerock
City Salem Mo
Registration District No. 266
Primary Registration District No. 4164
(No. ..... St. ..... Ward)
File No. .....
Registered No. 5

2. FULL NAME Thomas Harrison 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. 6 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 8-1842

7. AGE Years 85 Months 8 Days 18 If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) Warren Co
(STATE OR COUNTRY) Kig

PARENTS
10. NAME OF FATHER Henry Smith
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kig
12. MAIDEN NAME OF MOTHER Morgan
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tenn

14. INFORMANT Mrs Will Shelton
(Address)

15. FILED 1/27 1928 A. J. McMurtry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 25 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1928, to Jan 25, 1928 that I last saw him alive on Jan 24 1928, and that death occurred, on the date stated above, at 6:50 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute lobar Pneumonia
108 (duration) 10 yrs. mos. 4 ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? at place of death
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? symptomatic
(Signed) A. J. McMurtry, M. D
, 19 (Address) Salem 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 Empire Grangeard
DATE OF BURIAL 1/27 1928

20. UNDERTAKER N D Hobson
ADDRESS Salem Mo

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.