

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

Do not use this space.

2444

**1. PLACE OF DEATH**

County..... St. Louis  
Township..... Carondelet  
City..... Koch

Registration District No. 1123  
Primary Registration District No. 6248 B,  
Koch Robert Koch Hospital

File No.....  
Registered No. 30  
St. \_\_\_\_\_ Ward)

**2. FULL NAME** Obed Smith

(a) Residence. No. 649 Forest Ave., Webster Groves Mo.  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred X yrs. X mos. 4 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 Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 18 1907

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	20	4	4	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Obed Smith Sr.

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

12. MAIDEN NAME OF MOTHER Kath. Rafferty

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

14. INFORMANT R. Koch Hospital Records  
(Address) Koch, Mo.

15. Jan. 23 1928 FILED L. C. Obrock REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 22, 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1928, to Jan. 22, 1928, and that I last saw him alive on Jan. 22, 1928, at 8:15 P.M. and that death occurred, on the date stated above, at \_\_\_\_\_

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Pulmonary Tuberculosis  
December 1927 yrs. mos. ds.

CONTRIBUTORY Acute dilatation of stomach  
(SECONDARY) About 3 days yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH, Unknown

DID AN OPERATION PRECEDE DEATH? NO DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Sputum X Ray  
(Signed) A. J. Gallant M. D.

123, 1928 (Address) Koch Hospital  
\*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 Calvary Cem DATE OF BURIAL 1/25 1928

20. UNDERTAKER Drehmisen Horral ADDRESS 1405 Meade

X. 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.

