

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

Do not use this space.

6400

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **100**

File No.
Registered No. **1302**
St. Ward)

2. FULL NAME

(a) Residence. No. **1117 N. 18th** St. **05** 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widow**

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.
abt 50 - - -

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Housekeeper 2101**
(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) **Tennessee**

10. NAME OF FATHER **W. Smith**

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

12. MAIDEN NAME OF MOTHER **Margaret William**

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

14. INFORMANT **Miss Rowan** (Address) **City Hospital**

15. **FEB -1 1928** FILED **May Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Feb 2** 19**28**

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw him alive on 6/10 P.M., 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Shock & lacerations of fractured skull struck by auto in City of St. Louis Mo.

CONTRIBUTORY (SECONDARY) **Criminal Carelessness** (duration) yrs. mos. da.

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) **H. J. [Signature]**, M. D. (Address) **Coronal**

*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 **Shawnee town Del** DATE OF BURIAL **2/6 1928**

20. UNDERTAKER **Southern N. & L. Co** ADDRESS **1016 S. Adams**

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.

