

JUN 1

1928

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

Do not use this space.

9710

1. PLACE OF DEATH

County Livingston
Township
City Chillicothe (No. St. Ward)

Registration District No. 508
Primary Registration District No. 3026

File No.
Registered No. 18

2. FULL NAME

William Joe Smith

(a) Residence No. 419 Woodward 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

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

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

Dec 26 - 1927

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

1212

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at Home

(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)

Chillicothe Mo

10. NAME OF FATHER

G. B. Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Lucerne Mo

12. MAIDEN NAME OF MOTHER

Josie E. Cop

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Harris Mo

14.

INFORMANT
(Address)G. B. East
Chillicothe Mo

15.

FILED

3-10-28
Reuben Barney
REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 9 - 1928

17.

I HEREBY CERTIFY That I attended deceased from Feb. 20, 1928, to March 9, 1928 that I last saw him alive on March 9, 1928, and that death occurred, on the date stated above, at 9 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11A Influenza Pneumonia
(Bronchial)
(duration) yrs. mos. 18 ds.

CONTRIBUTORY (SECONDARY)

11A
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. DID AN OPERATION PRECEDE DEATH? no DATE OFWAS THERE AN AUTOPSY? noWHAT TEST CONFIRMED DIAGNOSIS? Physician of Examination(Signed) H. M. J. ... M. D.3-10-28 (Address) Chillicothe - 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

DATE OF BURIAL

Lucerne Mo.3-11 1928

20. UNDERTAKER

ADDRESS

F. B. Noonan Chillicothe 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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Livingston Registration District No. 308 File No.
 Township Primary Registration District No. 3024 Registered No. 18
 City Chillicothe (No.) St. Ward

2. FULL NAME William Joe 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. 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 w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) s

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 12-26-1926

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 26, 1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>1</u>	<u>2</u>	<u>13</u>	

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 9 - 1928

17. I HEREBY CERTIFY, That I attended deceased from to 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (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)

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)

14. INFORMANT (Address)

15. FILED 3-10-28 Reuben Barney REGISTER

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

20. UNDERTAKER

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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