

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

Do not use this space.

16336

1. PLACE OF DEATH

County Butler Registration District No. 89
 Township Paplar Bluff Primary Registration District No. 5131
 City P.P.B. (No. 127) St. Ward

File No. _____
 Reg. No. _____
 St. 127 Ward _____

2. FULL NAME

(a) Residence. No. 8 St. _____ Ward _____
 (Usual place of abode) P.P.B. (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Beverly John Smith

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

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
88 6 29

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Lived with son
 (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) Ohio

PARENTS

10. NAME OF FATHER John Bucklew

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT (Address) M.B. Smith
Paplar Bluff P.P.B. 4

15. FILED 31 1925 D. B. Cline REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1928

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1928, to May 27, 1928, that I last saw him alive on May 3, 1928, and that death occurred, on the date stated above, at 11:30 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute myocarditis
131
93A about (duration) 2 yrs. 2 mos. 2 ds.
CONTRIBUTORY (SECONDARY) hypertension, chronic
 about (duration) 1 yrs. 1 mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH 129A

8. DID AN OPERATION PRECEDE DEATH? DATE _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS (Signed) Alfred P. Cross, M. D.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Paplar Bluff Mo
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL City Secretary **DATE OF BURIAL** May 29 1928

20. UNDERTAKER N. T. Phelps **ADDRESS** Paplar Bluff Mo

1950-1951

1950-1951

1950-1951

1950-1951

1950-1951

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ALL INFORMATION CONTAINED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Butler Registration District No. 89 File No. _____
 Township Oscar Bluff Primary Registration District No. 9-131 Registered No. 127
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Katie 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 28 - 1839

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
88 6 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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) _____

14. INFORMANT _____ (Address) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 27 1928

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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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)

*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 _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

FILED 7/19 28 Dr. J. J. Cline
 REGISTER

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

