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

Registration District No. 309 File No. 16739

Primary Registration District No. 5427 Registered No. 23

PLACE OF DEATH

County Gentry

Township Athens

or Village

or City Stanberry Mo (No. ____ St.: ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mary Jane Smith

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| F | W | married to Leroy Smith |

DATE OF BIRTH May 21, 1858 (Month) (Day) (Year)

| AGE | If LESS than 1 day, ____ hrs. or ____ min.? |
|---|---|
| 69 yrs. 11 mos 18 ds. | |

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

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Iowa

PARENTS

NAME OF FATHER unk

BIRTHPLACE OF FATHER (City or town, State or foreign country) unk.

MAIDEN NAME OF MOTHER unk

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Iowa.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leroy Smith

(ADDRESS) Stanberry Mo R.4

Filed May 19, 1928 W. T. Martin REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 19, 1928 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 5-10-, 1928, to 5-19-, 1928 that I last saw h alive on 5-18-, 1928, and that death occurred, on the date stated above, at 10 45/60 m.

The CAUSE OF DEATH* was as follows:

59 Diabetes Mellitus

IRB 57

(Duration) 1+ yrs. ____ mos. ____ ds.

Contributory (Secondary) Gangrene of rt foot & leg

(Duration) ____ yrs. 1 mos. ____ ds.

(Signed) Frank H Rose M. D.

5-19-, 1928 (Address) Albany, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Eggleston Mo

DATE OF BURIAL 5/20, 1928

UNDERTAKER Latony & Phillips

ADDRESS Stanberry Mo

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... ..... St.; ..... Ward) [If dea
hospital
give its
of stree

# MISSOURI STATE BOARD OF H
## BUREAU OF VITAL STATISTI
### CERTIFICATE OF DEATH

FULL NAME .....

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | COLOR OR RACE | SINGLE<br>MARRIED<br>WIDOWED<br>OR DIVORCED<br>(*Write* the word) |
|---|---|---|
| | | |

DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ..... hrs. or ..... min.?

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

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..., .....
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) (I

I HEREBY CERTIFY, that I attended d

....., 191..., to.....

that I last saw h..... alive on .....

and that death occurred, on the date stated above.

The CAUSE OF DEATH* was as follows:.

.....

.....

.....

.....(Duration).....yrs.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mo

(Signed).....

....., 191... (Address).....

*State the Disease Causing Death, or, in deaths from Viole
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicida

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, T
RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....n

Where was disease contracted if not at place of death? .....

Former or usual residence.....

| PLACE OF BURIAL OR REMOVAL | DATE OF B |
|---|---|
| | |
| UNDERTAKER | ADDRESS |