

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

Do not use this space.

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Mason Primary Registration District No. 3029
City Stammbal (No. 109 South Lamb Ave.) St. _____ Ward _____

24437

File No. _____

Registered No. 203

2. FULL NAME

Nellie L. Smart
(a) Residence - No. 109 South Lamb Ave. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

Female White Widowed

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

James T. Smart

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

Oct 5 - 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
48 | 9 | 26

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) Palmyra
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER John Cox

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

12. MAIDEN NAME OF MOTHER Julia Irwin

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

14. INFORMANT Mrs. B. F. Smart
(Address) 308 Hawkins Ave

15. FILED 8/1, 1928 C. C. Strode
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 31, 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h. l. l. alive on _____, 19____, and that death occurred, on the date stated above, at 6:30 a. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Angina Pectoris

7 months 1 year (duration) mos. da.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? DID AN OPERATION PRECEDE DEATH? No. DATE OF _____WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) W. M. Smith 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

Palmyra _____ 19____

20. UNDERTAKER

ADDRESS

W. M. Smith Stammbal

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

ALL INFORMATION REQUESTED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Marion

Registration District No. 247

File No. _____

Township _____

Primary Registration District No. 3029

Registered No. 203

City Hannibal (No. _____)

St. _____

Ward _____

2. FULL NAME

Nellie L. Smart

(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 W (write the word)

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

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

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

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 _____

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 8/1 28 C. E. Stroe
 1928

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 31 19 28

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ 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)

*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 _____

8/2 19 28

20. UNDERTAKER _____

ADDRESS _____

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

SUPPLEMENTARY

S-24437