

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

Do not use this space.

33012

1. PLACE OF DEATH

County Cass Registration District No. 160
 Township West Dolar Primary Registration District No. 5225
 City (No.) Sl. Ward)

2. FULL NAME

Mary C. Smith

(a) Residence No. St. Ward. (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 Am 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
80 5 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
 (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) Leavenworth Kas.

10. NAME OF FATHER Nathan Shaler

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

12. MAIDEN NAME OF MOTHER Sarah Halbright

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

14. INFORMANT Mrs. Richard Smith (Address) Freeman Mo.

15. FILED Oct 8, 1928 Mary Meador REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 6 - 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 - 1928 to Oct 6 - 1928 that I last saw her alive on Oct 5 - 1928, and that death occurred, on the date stated above, at 8-05 - PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
17401
 CONTRIBUTORY Arterio Sclerosis (SECONDARY) (duration) 5 yrs. - mos. - ds.

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

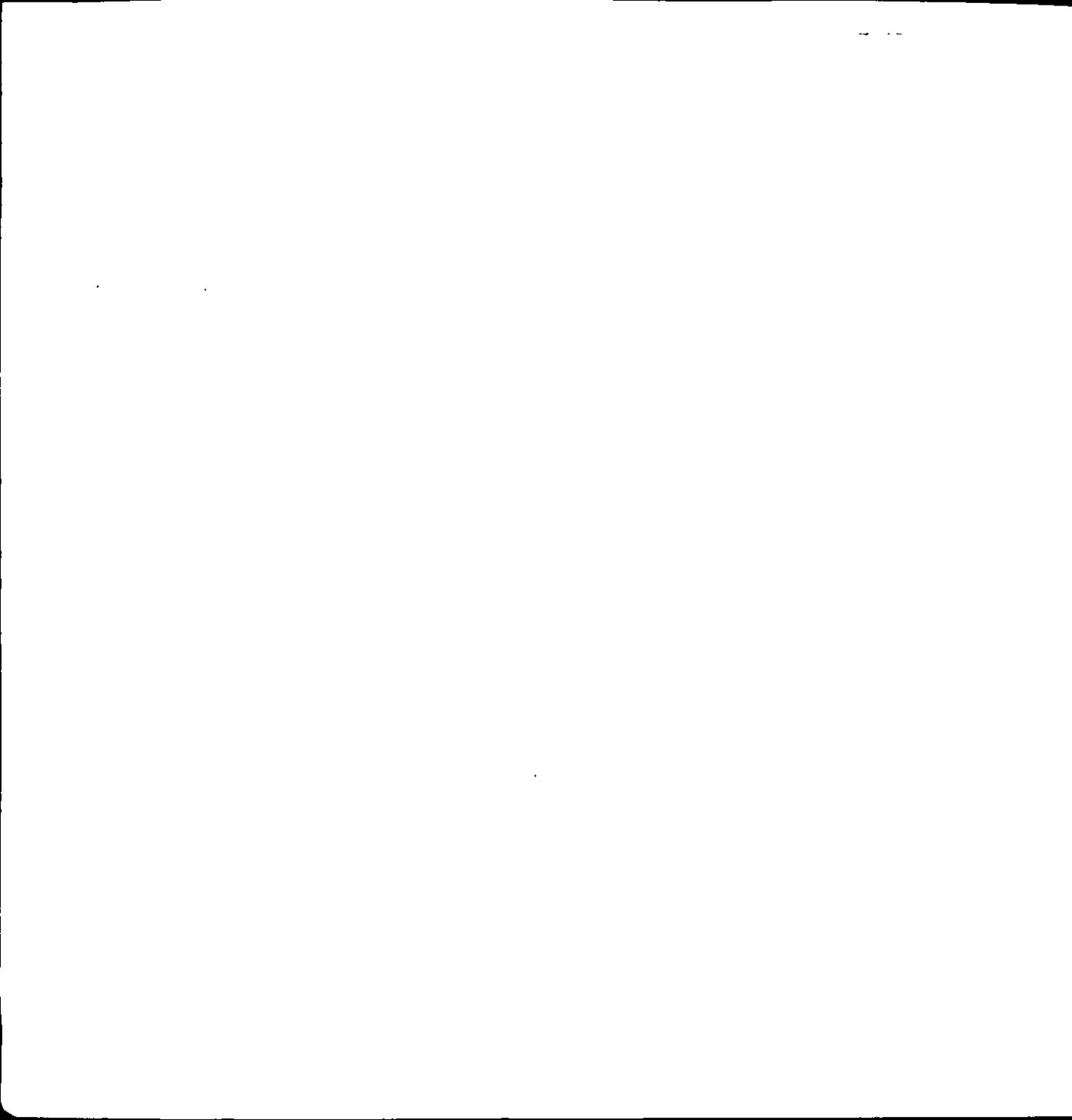
19. DID AN OPERATION PRECEDE DEATH? no DATE OF.....
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) J. H. Parrish, M. D.
Oct 7, 1928 (Address) Freeman 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 Shaler Cemetery DATE OF BURIAL Oct 8 1928

20. UNDERTAKER Clara B. Runyan ADDRESS Louisburg Kas.



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Cass Registration District No. 160 File No.
 Township West Dolan Primary Registration District No. 5-225- Registered No.
 City (No.) St. Ward)

2. FULL NAME

Mary C. 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) Wed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) May - 3 - 1848
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
80 5 3

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
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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 Oct 8 1928 Mary Meador REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 6 1928
 17. I HEREBY CERTIFY That I attended deceased from 19....., 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:

18. WHERE WAS DISEASE CONTRACTED (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
 ADDRESS 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 REGISTRAR

S-33012