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

Do not use this space.

7062

1. PLACE OF DEATH
County Lafayette — Registration District No. 461 — File No. 10
Township Lexington — Primary Registration District No. 3024 — Registered No.
City (No. St. Ward)

2. FULL NAME William H. Smock
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
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) Aug 10-1872

7. AGE: Years 56 — Months 5 — Days 23 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Truck Gardner
(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) Saline Co Mo

PARENTS
10. NAME OF FATHER James F. Smock
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Elizabeth Campbell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

14. INFORMANT Mrs Pinkie Taubman
(Address) Lexington Mo

15. FILED Feb 4, 1929 J. W. Cope, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 3 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1929, to Feb 3, 1929 that I last saw him alive on Feb 2, 1929, and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dilatation of heart
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Chronic Degenerative Myocarditis Pulmonary Phthisis
(duration) 2 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) [signature], M. D
Feb 4, 1929 (Address) Lexington 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: Lexington Mo — DATE OF BURIAL: Feb 4 1929

20. UNDERTAKER: Ernest Fegert — ADDRESS: Lexington 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.