

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

Do not use this space.

7758

**1. PLACE OF DEATH**

County St. Clair  
 Township Lebo  
 City William Alfred Smith

Registration District No. 770  
 Primary Registration District No. 6016

File No. ✓  
 Registered No. 38  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

William Alfred Smith

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)

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** Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Widower

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** Ella Mae Smith

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** 3-25-1866

**7. AGE** YEARS 62 MONTHS 10 DAYS 27 **IF LESS than 1 day, hrs. or min.**

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work Farmer 131 87  
 (b) General nature of industry, business, or establishment in which employed (or employer) 102  
 (c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Ill

**10. NAME OF FATHER** Oliver Smith

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

**12. MAIDEN NAME OF MOTHER** Sarah Diffaker

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

**14. INFORMANT** Elva Smith (Address) Rockville Mo

**15. FILED** Feb 26 1929 Georgia F. Davidson REGISTRAR

**4 MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Feb-17 1929

**17. I HEREBY CERTIFY** That I attended deceased from Feb. 9, 1929, to Feb. 17, 1929 that I last saw him alive on Feb. 16, 1929, and that death occurred, on the date stated above, at 11-30 P.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

cerebral pressure on breathing center. Old cerebral scar. Chronic nephritis.

**CONTRIBUTORY (SECONDARY)** Hypertension & an old cerebral scar (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

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

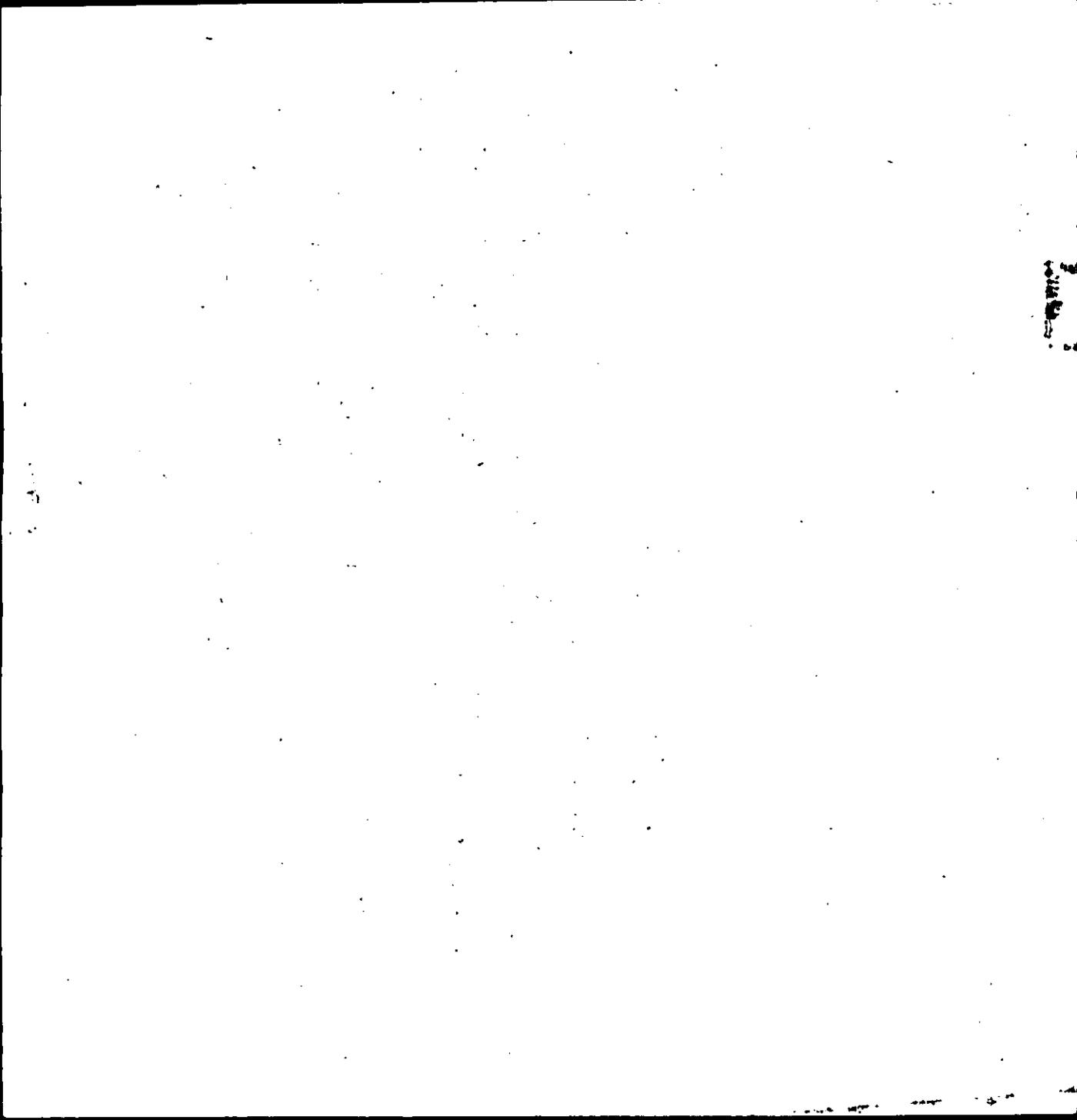
**DID AN OPERATION PRECEDE DEATH** NO **DATE OF** \_\_\_\_\_ **WAS THERE AN AUTOPSY** NO

**WHAT TEST CONFIRMED DIAGNOSIS** \_\_\_\_\_ (Signed) A. B. Freeman, M. D. 19 (Address) Rockville 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** Rockville Mo **DATE OF BURIAL** Feb 19 1929

**20. UNDERTAKER** Frank Lee Appleton **ADDRESS** City Mo



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Clair Registration District No. 770 File No. ....  
Township Tabor Primary Registration District No. 6126 Registered No. ....  
City..... (No. ....) St. .... Ward)

**2. FULL NAME**

William Alfred 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 m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (use the word) wid

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 Chas Smith

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT Elva Smith (Address) Rockyale Mo

15. FILED Feb 26 19 29 Georgia P. Baird REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 - 17 19 29

17. I HEREBY CERTIFY That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at .....

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

20. UNDERTAKER Frank Lee ADDRESS Appleton City Mo

SUPPLEMENTARY

PARENTS

REGISTRARS SHALL NOT RECEIVE FEE FOR CERTIFICATE

S-7758