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

Do not use this space.

8313

791

1003

File No. .....

Registered No. 1965

**1. PLACE OF DEATH**

County .....

Registration District No. .....

Township .....

Primary Registration District No. .....

City Morris (No. City Hospital St. ..... Ward)

16675

**2. FULL NAME** William Smoot

(a) Residence. No. 4231 Washington St. 19 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) |
|---|---|---|
| Male | White | Separated |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 25 - 1867

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| | 61 | 11 | 17 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

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

(c) Name of employer

173

9. BIRTHPLACE (CITY OR TOWN) Washington
(STATE OR COUNTRY) D.C.

2

PARENTS

10. NAME OF FATHER Wm Smoot Sr

2

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Washington D.C.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Head

2

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

14. INFORMANT Hospital Information
(Address) C. Rowan City Hospital

15. FILED FEB 11 1929, 19 Max C. Stanley Jr. REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 11 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 6, 1929, to Feb 11, 1929, that I last saw him alive on Feb 11, 1929, and that death occurred, on the date stated above, at 4:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of the ascending colon

46 C

95 C (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic myocarditis

(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) J. Johnson, M.D.

2/11/29 (Address) City Hospital

*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: Valhalla Crematory

DATE OF BURIAL: 2-12-1929

20. UNDERTAKER: Suedmeyer & Sons, 3934 N. 20th

ADDRESS

AT 2. 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.

Snoot
16675