

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

Do not use this space.

17179

1. PLACE OF DEATH

County Barry Registration District No. 30
Township Capshook Primary Registration District No. 0041
City Barry (No. 1) St. Barry Ward 1
Registered No. 49

2. FULL NAME Michael Smalley

(a) Residence, No. 1 St. Barry Ward 1
(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 M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 20 - 1852

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>76</u>	<u>4</u>	<u>19</u>	

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

10. NAME OF FATHER Michael Smalley

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

12. MOTHER NAME OF MOTHER Catherine Bruner

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

14. INFORMANT (Address) Hugh Mc Guinn
Bracefield Mo.

15. FILED 6-10-19-29 W. M. West REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/9/29

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 to Apr 29, 1929, and that I last saw him alive on Apr 24, 1929, and that death occurred, on the date stated above, at 8 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sarcema
46E
53E (duration) 1 1/2 yrs. mos. da.

CONTRIBUTORY (SECONDARY) no (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF ✓

20. WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Phys signs
(Signed) H. Rose Clark, M. D.
, 19 (Address) Prine City, Mo

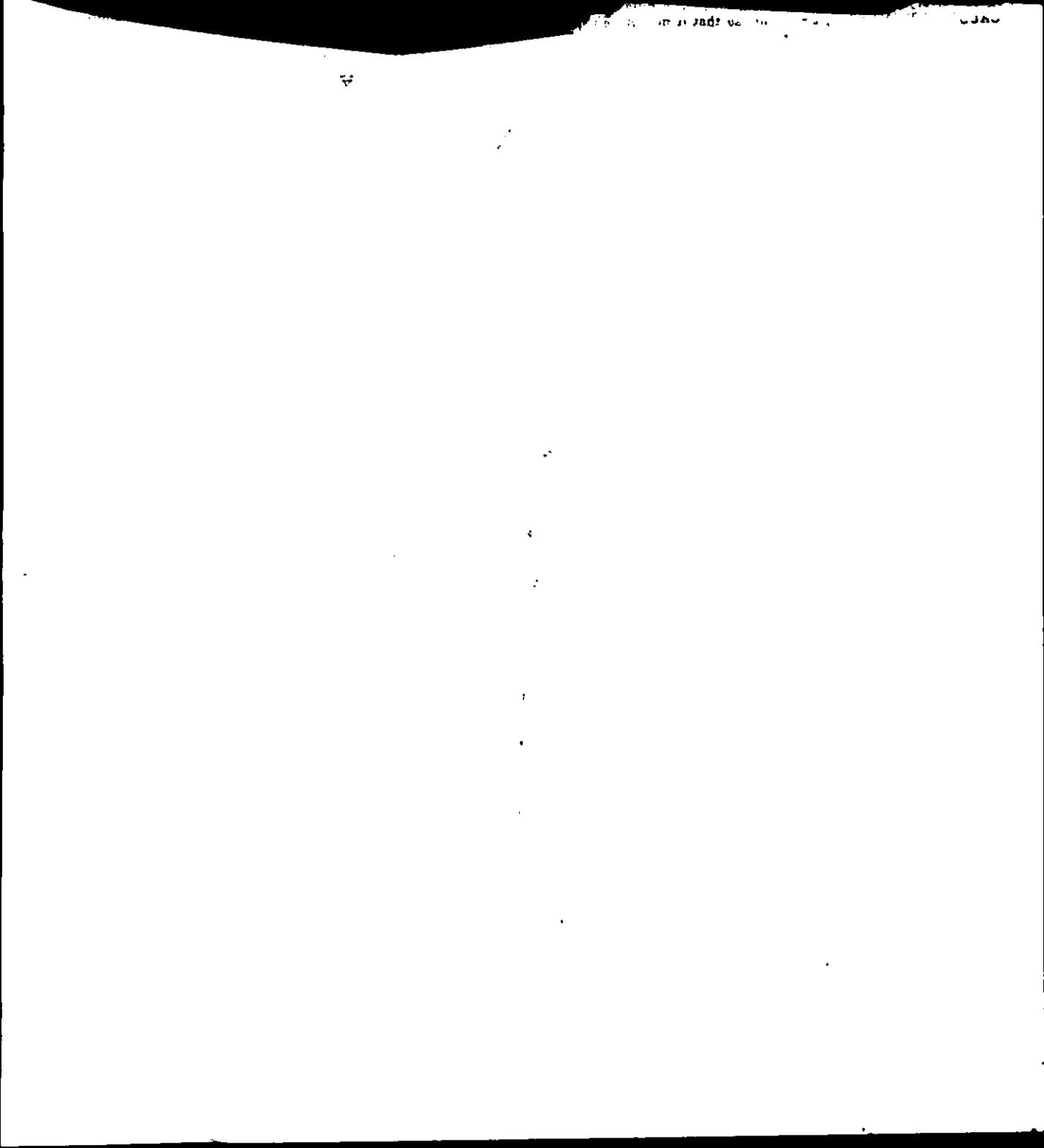
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

21. PLACE OF BURIAL, CREMATION, OR REMOVAL St Marys Cemetery DATE OF BURIAL May 11 1929

22. UNDERTAKER Wm J. Russell & Co ADDRESS Prine City, Mo

CAUSE OF DEATH... so that it may be properly recorded.

24125
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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Barry Registration District No. 30 File No. _____
 Township Capps Creek Primary Registration District No. 3041 Registered No. 49
 City _____ (No. _____ St. _____ Ward)

2. FULL NAME

Michael Smalsey
 (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 <u>m</u>		4. COLOR OR RACE <u>w</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>wid</u>	
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)					
PARENTS	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)				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/19 1929

17. I HEREBY CERTIFY that I attended deceased from _____ to _____, 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:
Sarcoma of back - right lumbar region, arising from ant. surface right ilium.
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 49
 (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 19 _____
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICA. AS PRESCRIBED BY LAW

14. INFORMANT (Address) _____
 15. FILED 8-5-29 W. M. West REGISTRAR

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