

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

Do not use this space.

38118

**1. PLACE OF DEATH**

County Ralls Co  
Township Clear  
City Hannibal (No. Ralls Co)

Registration District No. 728  
Primary Registration District No. 3961

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

**2. FULL NAME**

CHARLES HAWKINS SMITH

(a) Residence. No. Ralls Co 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 MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) MARCH 3 1843

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
86 8 27

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

9. BIRTHPLACE (CITY OR TOWN) MARION Co.  
(STATE OR COUNTRY)

10. NAME OF FATHER E. SMITH

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

12. MAIDEN NAME OF MOTHER Don't Know

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

14. INFORMANT Mr. Charles S. Smith  
(Address) Hannibal

15. Dec 29 1929 Marnie Short  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-30-1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Nov 30, 1929 that I last saw h. alive on Nov 29, 1929, and that death occurred, on the date stated above, at 6:27 a.m.

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

92A  
(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY) None  
(duration) 0 yrs. 0 mos. 0 ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Grand autopsy  
(Signed) A. S. Pharr, M. D.  
. 19 (Address) Hannibal 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 Riverside Cemetery DATE OF BURIAL 12-2-1929

20. UNDERTAKER James O'Donnell ADDRESS Hannibal Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.

