

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

Do not use this space.

40214

63

1. PLACE OF DEATH

County Dunklin
Township Buff.
City W.

Registration District No. 983
Primary Registration District No. 5402

File No. _____
Registered No. _____
St. _____ Ward)

2. FULL NAME

(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 10 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

6. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

C. E. Smith

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

Nov. 17, 1877

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
52	-	24	

8. OCCUPATION OF DECEASED

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

Housewife

(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)

White Co. Ill

10. NAME OF FATHER

Martin Russell

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

White Co. Ill

12. MAIDEN NAME OF MOTHER

Harristh Sidcom

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

White Co. Ill

14. INFORMANT

(Address)

C. E. Smith
Cardwell, Mo

15. FILED

1-10 1930

C. E. Newson
REGISTRAR

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

12-11 1929

17.

I HEREBY CERTIFY, That I attended deceased from Dec 8, 1929, to Dec 11, 1929,

that I last saw him alive on Dec 10, 1929, and that death occurred, on the date stated above, at 7:20 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia

12/6
12/13
109

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (SECONDARY)

Gall bladder disease

(duration) yrs. 5 mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

Cardwell Mo

1 DID AN OPERATION PRECEDE DEATH?

Yes DATE OF Nov 1 1929

WAS THERE AN AUTOPSY?

no

WHAT TEST CONFIRMED DIAGNOSIS?

none

(Signed) W. E. Ellington, M. D.

Dec 11 1929 (Address) Cardwell Mo Ill

*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

Buff. Twp. 12-11 1929

20. UNDERTAKER

ADDRESS

Liggs Und. Co. Cardwell

every item of information shown to certify support. AGE STATEMENT OF OCCUPATION is CAUSE OF DEATH in plain terms, so that it may be properly classified.

1930
29
2

1901

12

1001

1001

1001

1001

TAG

**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 Dunklin
Township Buffalo
City (No.) (Name) (Word)

Registration District No. 283
Primary Registration District No. 5402

File No. 40214
Registered No. 63

2. FULL NAME

Rosy 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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-11-29

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Infarction of Lobar

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

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.

CONTRIBUTORY Gall. bladder disease
(SECONDARY) Gall. Stone, underwent operation, never did recover,

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

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.

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

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)

INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

FILE 1-10-30

O. Newson
REGISTRAR

EXACTLY. PHYSICIANS & OTHERS MUST BE VERY IMPARTIAL IN THE PERCENT OF OCCUPATION IS VERY IMPORTANT. COMPLETE AS PRESCRIBED. FALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL.

5-4024