

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

Do not use this space.

40824  
5231

1. PLACE OF DEATH  
 County Jackson Registration District No. 399  
 Township Jaw  
 City Kansas City (No. Wheately Over Hoop)  
 Primary Registration District No. 3  
 2. FULL NAME Lloyd B. Smith  
 (a) Residence. No. 1221 Everett St., K.C. 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 Colored  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 22, 1887  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
47 2 23  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Porter  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer Nash-Lery Motors

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas  
 10. NAME OF FATHER Ellis Smith  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Texas  
 12. MAIDEN NAME OF MOTHER Lora Johnson  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Texas

14. INFORMANT Helen Smith  
 (Address) 1221 Everett St., K.C.  
 15. FILED 19 29 M. M. Crane  
 REGISTRAR Asst.

**MEDICAL CERTIFICATE OF DEATH**

2  
 16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/15 1929  
 17. I HEREBY CERTIFY, That I attended deceased from Dec-7, 1929, to Dec-15, 1929 that I last saw him alive on Dec-14, 1929 and that death occurred, on the date stated above, at 3:50 P.M.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Sub-diaphragmatic abscess (part of liver)  
129  
1929 (duration) 7 yrs. - 15 mos. - 15 ds.  
 CONTRIBUTORY Gen. Peritonitis (SECONDARY) (duration) - yrs. - 5 mos. - 5 ds.  
 18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 19. DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? Yes  
 WHAT TEST CONFIRMED DIAGNOSIS? Post mortem  
 (Signed) D. Orsted M. D.  
 (Address) 422 Min. K.C. Kans  
 \*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 Solix, Texas DATE OF BURIAL 1/20 19 29  
 20. UNDERTAKER Hatkins Bros. ADDRESS 1729 Lydia

N. B.—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.

245  
2

STATE OF TEXAS  
COUNTY OF DALLAS

1887

**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..... Registration District No. 399 File No. ....  
 Township..... Primary Registration District No. 1002 Registered No. 3231  
 City K. City (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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

*Lloyd Smith*

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED m  
(write the word)

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

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)

PARENTS

SUPPLEMENTARY

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/15/29

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Sub-diaphragmatic abscess (to rt. liver) neither tubercular nor pyogenic*

CONTRIBUTORY *Gen. Toxemia* (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) *Porter Davis*, M. D.

(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

15. FILED 7/9, 19 29 *M. M. Crave* REGISTRAR

A. Porter Davis  
422 Mission Ave

S-40824

REPRODUCED