

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

Do not use this space.

43301

PLACE OF DEATH

County Worth
Township Union
City Shenandoah (No.)

Registration District No. 904
Primary Registration District No. 6315

File No.
Registered No.
St. Ward)

2. FULL NAME Lacey Hayes Smith-Childers
(a) Residence. No. Shenandoah Mo. Word.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 47 yrs. mos. da. How long in U.S., if of foreign birth? 47 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Wm. Childers

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11 16 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
47 11 16

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) Grant City Mo.
(STATE OR COUNTRY) Worth Co.

10. NAME OF FATHER Dudley W. Smith

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

12. MAIDEN NAME OF MOTHER Shumer

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

14. INFORMANT Wm. Childers
(Address) Shenandoah Mo.

15. FILED 12/18 1929 JW Nugh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 17 1929

17. I HEREBY CERTIFY, That I attended deceased from 8:30 to Dec. 17, 1929, that I last saw her alive on Dec. 12, 1929, and that death occurred, on the date stated above, at 11:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral insufficiency of heart
92R

(duration) 4 yrs. mos. da.

CONTRIBUTORY (SECONDARY) JAW
(duration) ____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED JAW
IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Repeal findings
(Signed) E. J. Ralston, M. D.
, 19 (Address) Grant City 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 Isadora Cemetery DATE OF BURIAL Dec 19 1929

20. UNDERTAKER Long & Boyd Shenandoah, Mo. ADDRESS

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.

WRITE PENMAN, WITH UNIFORM INK—THIS IS A PERMANENT RECORD

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10-18-29
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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 Worth Registration District No. 904 File No. _____
 Township Union Primary Registration District No. 6215 Registered No. _____
 City _____ No. _____ St. _____ Ward _____

2. FULL NAME Lucy Hayes S. Childers
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1 - 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 19 16

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) _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 17 1929

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 _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
 _____ (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (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) _____, 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

14. INFORMANT _____ (Address) _____

15. FILED 12/18 1929 JW High REGISTRAR

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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