

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

Do not use this space.

1. PLACE OF DEATH

County ADAIR Registration District No. 4
 Township KIRKSVILLE MO Primary Registration District No. 5005
 City KIRKSVILLE MO (No. COUNTY FARM St. _____ Ward)

File No. 12
 Registered No. 13

2. FULL NAME

ANOCH SMITH
 (a) Residence. No. COUNTY FARM 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 W	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) MARRIED
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF MARRIED		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) JAN 1 1843		
7. AGE YEARS 87	MONTHS 00	DAY 26
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 SELF		

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) **IND**

PARENTS

10. NAME OF FATHER DAVIS SMITH
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) OHIO
12. MAIDEN NAME OF MOTHER NANCY SMITH, SAME
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) OHIO

14. INFORMANT Mrs Geo Johnson, Supt
 (Address) KIRKSVILLE MO

15. FILED 1/31 1930 Ed Becker Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **1-27 1930**

17. I HEREBY CERTIFY, That I attended deceased from 9-1 to 1-27-30 that I last saw him alive on 1-26 and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis
12 1/2 yrs (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) None (duration) yrs. mos. 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 Laboratory
 (Signed) C. M. C. Wilcox, M. D.
 NAME, 19 (Address) Kirkville 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 **BUTTE MONT** DATE OF BURIAL **2-4 1930**

20. UNDERTAKER David Wilson ADDRESS Kirkville

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.

1936-1-27
1843-~~1-27~~

7 0 26