

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

Do not use this space.

374

1. PLACE OF DEATH

County Cassaway Co

Registration District No. 104

Township Union no

Primary Registration District No. 300

City Union no

File No. _____

Registered No. 22

St. _____

Ward _____

2. FULL NAME Mr. H. (Low) Smith

(a) Residence. No. Cassaway Mo. St. _____ Ward. _____

State Hospital No. 1
(If nonresident give city, state and street)

Length of residence in city or town where death occurred _____ yrs. mos. 15 ds.

How long in U.S., if of foreign birth? _____ yrs. mos. 15 ds.

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 OR (OR) WIFE OF Mrs. Mason

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

7. AGE

YEARS 57

MONTHS —

DAYS —

IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED Housekeeper

(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)

14.

INFORMANT State Hospital No. 1
(Address) Union no

15.

FILED Jan 28, 1930 R. N. Creed
REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 28, 1930

17.

I HEREBY CERTIFY, That I attended deceased from _____, 1930, to _____, 1930 that I last saw her alive on Jan 28, 1930 and that death occurred, on the date stated above, at 11:00 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Phonetic Pneumonia

CONTRIBUTORY (SECONDARY) _____

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: no

DID AN OPERATION PRECEDE DEATH: no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Phonetic

(Signed) _____

, 19 _____

(Address) State Hospital No. 1

*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. Phonetic

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____

DATE OF BURIAL Jan 30, 1930

20. UNDERTAKER Jan M @ Harry Columbia

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.

14
28
7

230
31

PARENTS

FILED

28

