

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

Do not use this space.

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K. B.—Every item of information should be carefully supplied. AGE should be state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION if very important.

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**1. PLACE OF DEATH**

County Franklin Registration District No. 295  
 Township Sullivan Primary Registration District No. 4129  
 City Sullivan Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

**2. FULL NAME**

Nancy Jane 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 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Greley Smith</u>			
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>May 29, 1861</u>			
7. AGE	YEARS	MONTHS	DAYS
	<u>68</u>	<u>7</u>	<u>20</u>
If LESS than 1 day, _____ hrs. or _____ min.			
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>At home</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____			

9. BIRTHPLACE (CITY OR TOWN) Cave Spring Mo  
 (STATE OR COUNTRY)

10. NAME OF FATHER <u>Henry Doyle</u>
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>England</u>
12. MAIDEN NAME OF MOTHER <u>Mary Watson</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Tennessee</u>

14. INFORMANT Mrs. A. N. Busch  
 (Address) 3247 Morganford Rd  
St. Louis, Mo.

FILED \_\_\_\_\_ 19 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

1. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 28, 1930  
 17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19 \_\_\_\_\_, to \_\_\_\_\_, 19 \_\_\_\_\_, that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_, and that death occurred, on the date stated above, at 5:30 P.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral hemorrhage, apoplexy  
87 H (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) unknown  
 (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 \_\_\_\_\_

(Signed) Thos. P. Shaffer corner \_\_\_\_\_, M. D.  
Jan 28, 1930 (Address) Sullivan, 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 Cave Spring Cemetery DATE OF BURIAL Jan 30, 1930

20. UNDERTAKER Thos. P. Shaffer ADDRESS Sullivan, Mo

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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 Franklin Registration District No. 295- File No. ....  
 Township ..... Primary Registration District No. 4199 Registered No. 1  
 City Sullivan (No. ....) St. .... Ward)

2. FULL NAME Nancy Jane 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**

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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hra. or .....min.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.  
 (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 (Address)

15. FILED Jan 30 1930 Jas. Lemigan REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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  
 ADDRESS 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

K. 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

RECORD

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