

MR 27 1930

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

5395

1. PLACE OF DEATH

County Jasper Registration District No. 411 File No. 74  
Township Jasper Primary Registration District No. 2,002 Hosp Registered No. 74  
City Jasper No.        St.        Ward)       

2. FULL NAME

Claud A. 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 M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF         
6. DATE OF BIRTH (MONTH, DAY AND YEAR) no Record  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 26 — — — —

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work merchant  
(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) N. Y. State

10. NAME OF FATHER W. H. Hays  
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) Mrs. Elsie DeKernan 124 1/2 Main St

15. FILED 9/14 1930 A. Benson Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-12-30 1930  
17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1930 to 2-12-30 1930 that I last saw alive on 2-12-30 and that death occurred, on the date stated above, at 3-15-P.m.  
THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pulmonary hemorrhage  
(duration) yrs. mos. ds.         
CONTRIBUTORY (SECONDARY) retained lung following pneumonia yrs. mos. ds.       

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

8 DID AN OPERATION PRECEDE DEATH?        DATE OF       

WAS THERE AN AUTOPSY?       

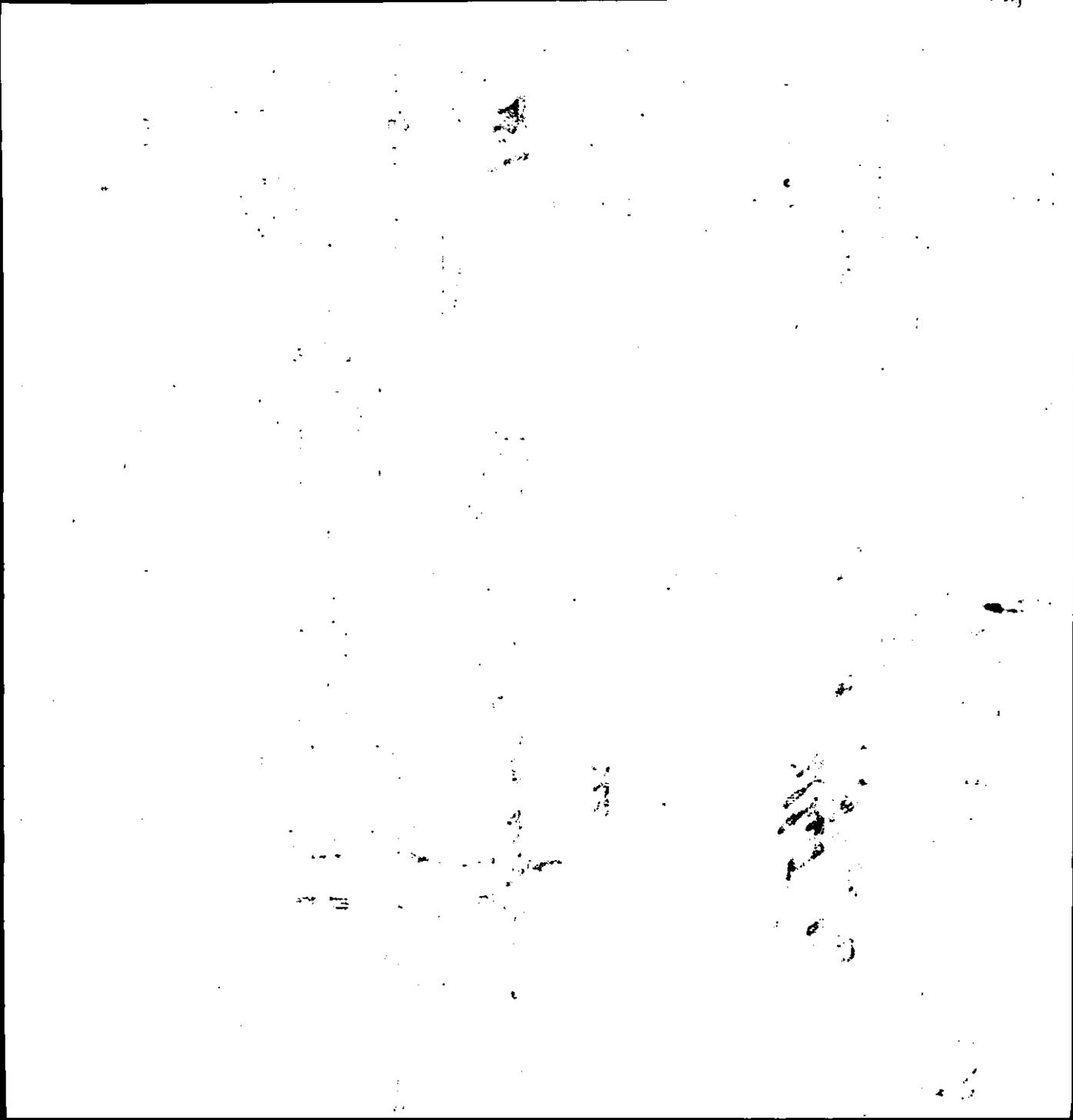
WHAT TEST CONFIRMED DIAGNOSIS? (Signed) J. Albert Phenow  
2-14-30 (Address) John Mo.

\*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 Open View PK DATE OF BURIAL 2/14 1930

20. UNDERTAKER (Address) Wentworth & Co ADDRESS forester

121



**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 Jasper Registration District No. 411 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 2002 Registered No. \_\_\_\_\_  
 City Joplin (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Claude A. 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. da. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/12 19 30

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

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

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

Unusual Hemorrhage  
of the brain

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 \_\_\_\_\_

abscessed lung  
following pneumonia

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPEY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_, M. D.  
 \_\_\_\_\_, 19 \_\_\_\_\_ (Address)

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 2/12/30 Person Clark REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_ 19 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY

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

CAUSE OF DEATH IN BIRTH CERTS, SO THAT IT MAY BE PROPERLY

S-5395