

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

Do not use this space.

7158

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City St. Louis (No. Bethesda Home) St. Ward)

File No.
Registered No. 2031

2. FULL NAME

Belle Smith
(a) Residence. No. 3651 Vista Ave St. 15 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1846??????

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 84 Unknown

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

10. NAME OF FATHER Wesam Smith

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

12. MAIDEN NAME OF MOTHER Helen Boyd

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

14. INFORMANT Frank W. Murdoch
(Address) 4734A Grand Ave

15. FILED 21 1930 Wm C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-24-1930

17. I HEREBY CERTIFY, That I attended deceased from 4-1-28 19..... to 2-24- 1930 that I last saw her alive on 2-24-1930 and that death occurred, on the date stated above, at 7:00 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia Broncho
135A (duration) yrs. mos. 8 ds.
107A
CONTRIBUTORY Pneumonia
(SECONDARY) (duration) yrs. mos. 8 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) Wm H. Reely M. D.
, 19 (Address) 3647 Vista

*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 Valhalla Cemetery DATE OF BURIAL 2/26/1930

20. UMBERTAKER Chas. L. Geaghey & Son ADDRESS 4259 Lindell Ave

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.

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