

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

Do not use this space.

8048

1. PLACE OF BIRTH
 County Chariton Registration District No. 175
 Township Salisbury Mo. Primary Registration District No. 4104
 City Salisbury Mo. (No. _____) St. _____ (Ward _____)

2. FULL NAME Allen Lewis Smith
 (a) Residence No. Salisbury Mo 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. 6 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) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 26, 1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 | 8 | 28

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER William A. Smith

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs Lillie Jones
 (Address) Salisbury Mo

15. FILED 3/24 1930 J. H. Hawkins
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-24-30

17. I HEREBY CERTIFY, That I attended deceased from 3-24-30, 19____, to 3-24-30, 19____, that I last saw him alive on 3-24-30, 19____, and that death occurred, on the date stated above, at 2 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral apoplexy

CONTRIBUTORY (SECONDARY) Arterio Sclerosis
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Ill
 IF NOT AT PLACE OF BIRTH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Ralph Williams M. D.
3/24, 1930 (Address) Salisbury 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 Antioch Cemetery Mo. DATE OF BURIAL 3-26 1930

20. UNDERTAKER L. S. Murrie ADDRESS Salisbury Mo

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.

APR 23 1930

