

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

Do not use this space.

13331

1. PLACE OF DEATH

County Marion
Township Mason
City Hannibal (No. 501 Walnut)

Registration District No. 547
Primary Registration District No. 3629

File No. 105
Registered No. 101
St. 4 Ward

2. FULL NAME

Miss Kate Smith
501 Walnut St. 4 Ward.

(a) Residence. No. 501 Walnut St. 4 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 1, 1868

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
62 6 10

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Lacon, Ill
(STATE OR COUNTRY)

10. NAME OF FATHER Jas. Smith

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

12. MAIDEN NAME OF MOTHER Mary Sheridan

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

14. INFORMANT Joseph Murphy
(Address) Hannibal, Mo.

15. FILED 4/7 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/11 1930

17. I HEREBY CERTIFY, That I attended deceased from 4/11 1930 to 4/11 1930 that I last saw her alive on 4/11 1930, and that death occurred, on the date stated above, at 12:39 a.m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:

131 Crebra
137B

CONTRIBUTORY (SECONDARY) Chronic Pancreatitis (duration) 1 yrs. 1 mo. 1 ds.
nephritis (duration) 1 yrs. 1 mo. 1 ds.

18. THERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH 10/1/1868
DID AN OPERATION PRECEDE DEATH? no DATE OF no
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Chemist
(Signed) J. P. Farver M. D.
(Address) Hannibal 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 St. Marys Cem DATE OF BURIAL 4/14 1930

20. UNDERTAKER Jas. O'Donne ADDRESS Hannibal, 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.

MAY 27 1930

61-2-10

**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 Marion

Registration District No. 547

File No.

Township

Primary Registration District No. 2029

Registered No. 101

City Hannibal

St. (Ward)

2. FULL NAME

Kate 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)

S

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

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

Oct-1-1868

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

61

6

10

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

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 4/17 1930

W. C. Lourens
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

4/11 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..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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

19

20. UNDERTAKER

ADDRESS

N. B. ... 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

SUPPLEMENTARY

S-13331