

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

Do not use this space.

16964

1. PLACE OF DEATH
 County Pettis Registration District No. 667
 Township _____ Primary Registration District No. 3039
 City Sedalia (No. _____) St. _____ (If nonresident, give city or town and State) Ward _____

2. FULL NAME William Turkish Smith
 (a) Residence. No. 221 E Morgan 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** Col **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 22 - 1905

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
	<u>24</u>	<u>9</u>	<u>11</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Hotel Waiter
 (b) General nature of industry, business, or establishment in which employed (or employer) X
 (c) Name of employer Don't no

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cooper Co Mo

10. NAME OF FATHER John Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Cooper Co Mo

12. MAIDEN NAME OF MOTHER Ella Burris

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Cooper Co Mo

PARENTS

14. INFORMANT John Smith
 (Address) Sedalia Mo

15. FILED 5-7-30 J. J. Love REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-4-30 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-7-30 to 5-4-30, 1930 that I last saw him alive on 5-4-30, 1930 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute dilatation of heart
23A
9519 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Tubercular Pneumonia
 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Clinical & laboratory
 (Signed) A. R. Maddox, M. D.
 . 19 _____ (Address) 116 1/2 W. Main

*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 Sedalia Mo **DATE OF BURIAL** 5/8 1930

20. UNDERTAKER F. D. Ferguson **ADDRESS** Sedalia

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

JUN 27 1930

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