

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

Do not use this space.

19581
2582

1. PLACE OF DEATH: Fickler
 County: Franklin Registration District No. 2 File No. 17-17-30
 Township: Franklin Primary Registration District No. 17-17-30 Registered No. 2582
 City: Franklin (No. 17-17-30) Highways Highway St. Franklin Ward 2
 2. FULL NAME: Chas. Smith
 (a) Residence. No. 1216 Barfield St. 2 Ward. 2 (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: Male
 4. COLOR OR RACE: negro
 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): Unknown
 7. AGE: YEARS 40 MONTHS _____ DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work: P.R. Employee
 (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): Natcha Don
 10. NAME OF FATHER: Ward
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): North Ky
 12. MAIDEN NAME OF MOTHER: Ward
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): North Ky

14. INFORMANT: Wm. M. Smith
 (Address) 135 E. Church
 15. FILED: 6/22, 1930 W. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 6-17-30
 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:

Acute Dilatation of Heart
12A
0513
 CONTRIBUTORY (SECONDARY) Heart Regurgitation
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED: Now
 IF NOT AT PLACE OF DEATH: _____
 19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? Yes
 WHAT TEST CONFIRMED DIAGNOSIS: Autopsy
 (Signed) W. M. Crowe M. D.
 (Address) Deputy Coroner
 20. 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: Franklin Cemetery DATE OF BURIAL: 6-21-30
 20. UNDERTAKER: W. M. Crowe ADDRESS: 1717 Vine

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.

