

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

Do not use this space.

20448 ~~20545~~

PLACE OF DEATH

County St. Francois
Township St. Francois
City Near Farmington, Mo.

Registration District No. 773
Primary Registration District No. 6018A

File No. _____
Registered No. 87 Ward _____

2. FULL NAME Calvin E. Smith

(a) Residence. No. Farmington, 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. _____ 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) Unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>about</u>	<u>54</u>	<u>?</u>	<u>?</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(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) St. Francois County, Mo.

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY) St. Francois Co. Mo.

14. INFORMANT Hospital Records
(Address) Farmington, Mo.

15. FILED 6/6/30 B. J. C. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-5 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia (Left Side)
237
108
_____ (duration) _____ yrs. _____ mos. 5 ds.

CONTRIBUTORY Pulmonary Tuberculosis
(SECONDARY) _____ (duration) 5 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH Farmington, Route 3,
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) J. C. Fincher, M. D.

June 5 19 30 (Address) Farmington, 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 Cantwell Mo DATE OF BURIAL 6-7-30

20. UNDERTAKER C. L. Boyer ADDRESS Illslose

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important.

COPY WITH UPDATING INK—THIS IS A PERMANENT RECORD

