

AUG 20 1930

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.

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

Do not use this space.

22112

1. PLACE OF DEATH
 County Waplesburg Registration District No. 104
 Township Fulton Mo Primary Registration District No. 3006
 City Fulton Mo (No. _____) St. _____ Ward _____

2. FULL NAME Mrs Samantha Ann Smith
 (a) Residence No. Schuyler Co Mo St. _____ Ward State Hospital Nat
 (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? 5 yrs. _____ mos. _____ ds.

File No. _____
 Registered No. 150
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) DS
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF DS
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
Abt 78 — — — — —
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Home wife
 (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 Acquaintance Hospital No 1
 (Address) Fulton Mo

15. FILED 7-8-30 R. M. Crews
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
 16. DATE OF DEATH (MONTH, DAY AND YEAR) Jul 7 / 1930
 17. I HEREBY CERTIFY, That I attended deceased from Salt 15 - 1927 to Jul 7 / 1930 that I last saw h. alive on Jul 7 / 1930 and that death occurred, on the date stated above, at 108 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Garb. Entertis
120B
16R

(duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Senile Psychosis
Super depression
 (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical
 (Signed) [Signature] M.D.
 , 19 State Hospital No 1 (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 Glenwood, Mo, DATE OF BURIAL D, K, 19

20. UNDERTAKER Herndon-Taylor Furn-Co, ADDRESS Fulton, Mo,

Mary Hall
Bloomfield
Iowa

Summit Ind. 10 5 0