

SEP 24 1930

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

Do not use this space.

Dr. Green
100 26 393

1. PLACE OF DEATH

County *Creech* Registration District No. *2830* File No. *100 26 393*
Township _____ Primary Registration District No. *2701* Registered No. *98*
City *Springfield, Mo.* (No. *St. John's Hospital*) St. _____ Ward _____

2. FULL NAME

(a) Residence No. *Lebanon, 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 *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *married* (write the word)

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
about 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Lebanon Carpenter*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *Deer Co. Missouri*
(STATE OR COUNTRY)

10. NAME OF FATHER *Ed Smart*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Deer Co. Missouri*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Lue McDonald*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Deer Co. Missouri*
(STATE OR COUNTRY)

14. INFORMANT *Rachel Smart*
(Address) *Lebanon, Mo.*

15. FILED *8-7-30* *For Sharp* REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Embolic lesion following valve closure operation
1928

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *Lebanon Mo*
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? *yes* DATE OF *8-5-30*

WHAT TEST CONFIRMED DIAGNOSIS *Symptoms*

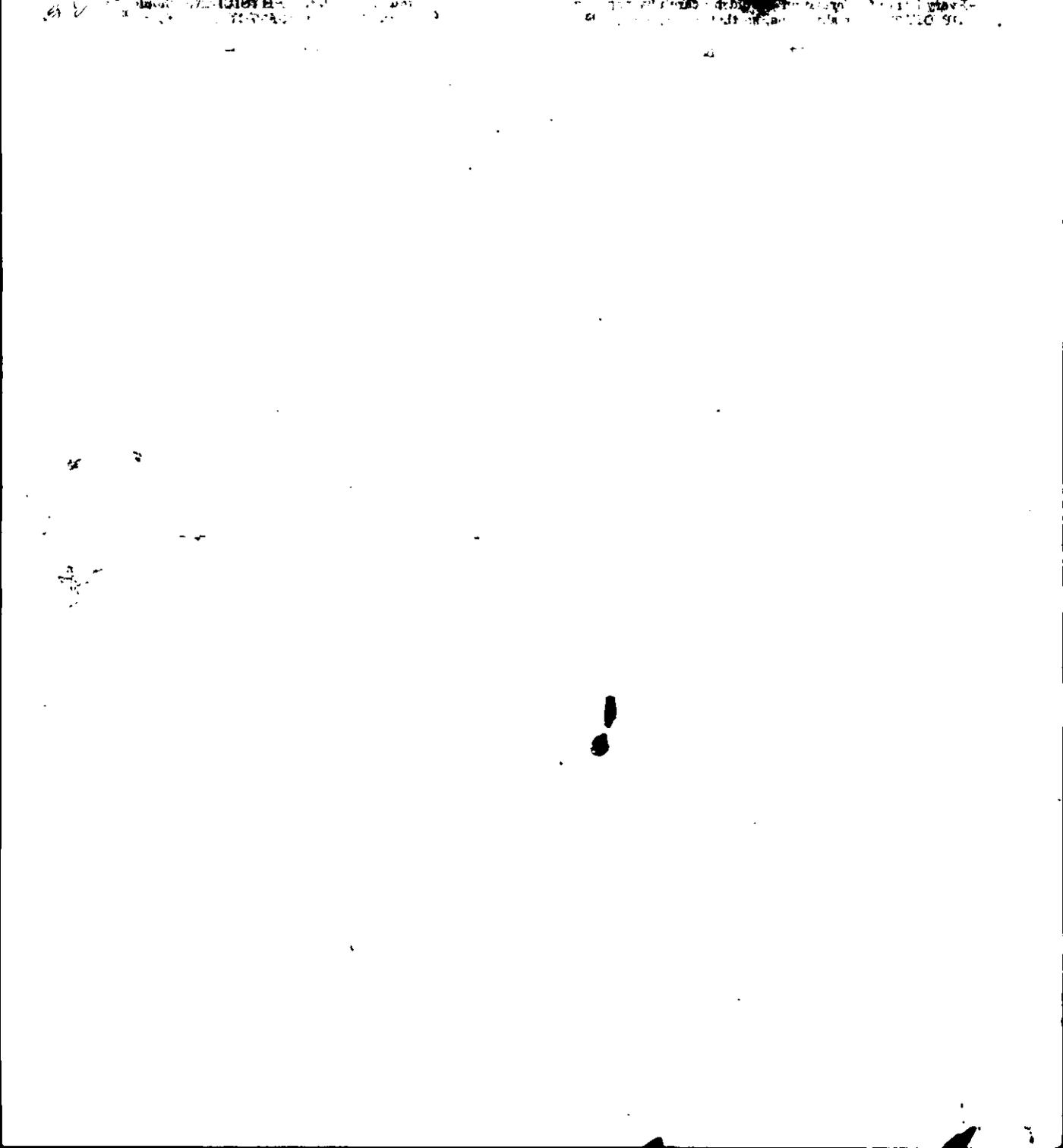
(Signed) *H. H. H. H.*, M. D.
8/6, 1930 (Address) *Springfield Mo*

*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 *Lebanon* DATE OF BURIAL _____

20. UNDERTAKER *Alma Spence* ADDRESS *Springfield Missouri*

N. B.—Every item of information should be carefully supplied. Age should be stated EARLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



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