

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

Do not use this space.

26561

1. PLACE OF DEATH

County Jackson
Township Bellevue
City Independence

Registration District No. 398
Primary Registration District No. 310.19
(No. Independence Sanborn)

File No. _____
Registered No. 275
St. _____ Ward _____

2. FULL NAME

Vida Jane Smith

(a) Residence. No. Sudgell + Crane Ave. 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec-10-1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
72 8 20

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Leas Summit Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER John Brown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Leas Summit Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Rebecca Mass

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Leas Summit Mo.
(STATE OR COUNTRY)

14. INFORMANT Mr. Lee W. Hedges
(Address) Sudgell + Crane Ave.

15. FILED 9-2, 19 1930
J. H. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 30 19 30

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Aug 30, 1930, that I last saw her alive on Aug 27, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardio Renal disease
4/10/30 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) Chas E. Jackson, M. D.

9/2, 19 30 (Address) Independence, 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 Blue Springs Mo. Sep-1 19 30

20. UNDERTAKER Wm. Mitchell ADDRESS _____

Every item of information should be accurately 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**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Jackson Registration District No. 398 File No.
 Township Indep Primary Registration District No. 3019 Registered No.
 City Indep (No.) St. Ward)

2. FULL NAME Viola Jane Smith
 (a) Residence No. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 10-1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. of min.
71 8 20

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work
 (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)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 30 1930

17. I HEREBY CERTIFY That I attended deceased from 19....., 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:
 (duration)..... yrs. mos. ds.
 CONTRIBUTORY (SECONDARY)
 (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed)....., M. D.
 , 19 (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.

14. INFORMANT (Address)
Oct 4 1930 F. L. Cook
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19
 ADDRESS

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 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 OCCASION is very important.

SUPPLEMENTARY

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