

OCT 30 1933

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

Do not use this space.

1. PLACE OF DEATH

County Linn Registration District No. 502
Township Macedonia Primary Registration District No. 4805
City Marceline (No. Metropolitan Hospital) St. 43 Ward

File No. 30438

2. FULL NAME

(a) Residence. No. John B J Smith 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 (write the word)

married

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

Mrs Maggie Smith

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

don't know

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>67</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) Indiana

10. NAME OF FATHER

Chas R. Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ind.

12. MAIDEN NAME OF MOTHER

Anna E.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Kent. town

14. INFORMANT

Mrs Maggie Smith
(Address) Marceline Mo

15. FILED

9/25/30 Ola Putman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Sept - 21 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 21 1930 to Sept 21 1930 that I last saw him alive on Sept 21 1930 and that death occurred, on the date stated above, at 9:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture of Skull.
Struck by auto.
2:00 PM
7:12 PM (duration) yrs. mos. shown ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. 48

DID AN OPERATION PRECEDE DEATH? no DATE 11

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) W. M. Pater M. D.
9/24 1930 (Address) Marceline 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

Ringo Cemetery DATE OF BURIAL Sept 24 1930

20. UNDERTAKER
Jas McLaughlin ADDRESS Marceline

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.

The victim was riding on a mule on Highway #36,
about 5 miles from Marceline in Linn County.

It was not a collision - two cars met and the man
on the mule was not seen in time to avoid hitting
him. Apparently the mule could not be managed
and wouldn't get off the highway.

Driver was not drunk , nor driving at an excessive
rate of speed.

As far as is known, blinding headlights had nothing
to do with the accident.

**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 Linn Registration District No. 202 File No.
 Township Primary Registration District No. 7305- Registered No. 43
 City Marceline No. St. Ward)

2. FULL NAME

John B. J. 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

3. SEX M 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)

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

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)

14.

INFORMANT (Address)

15.

FILED....., 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21 1930

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19.....
 (that I last saw h..... alive on....., 1B....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Fracture of skull struck by auto

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds. 1880

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?..... b

(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.

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

19

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY