

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.

DEC 20 1930

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

Do not use this space.

1. PLACE OF DEATH
County Buchanan Registration District No. 85
Township _____ Primary Registration District No. 1001
City St. Joseph, (No. St. Joseph's Hospital) St. _____ (Ward)

File No. 35363
Registered No. 1105

2. FULL NAME Eliza Smith,
(a) Residence, No. _____ St. _____ Ward Tingley, IOWA,
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 9 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) Widowed,
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John W. Smith,
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Year 1854
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 76 Unk. Unk.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home,
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) Unknown,

10. NAME OF FATHER Unknown,
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) Unk. born,
12. MAIDEN NAME OF MOTHER Unknown,
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) Unknown,

14. INFORMANT Hospital Records
(Address) St. Joseph, Mo.

15. FILED 1930 John G. W. REGISTRAR
NOV 3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 14 1930
17. I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1930, to Nov. 14, 1930 that I last saw h. e. alive on Nov. 14, 1930, and that death occurred, on the date stated above, at 7:00 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes & Jaundice of
Port & Leg
Reflex & Similar
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH. Mr. Cox Dr
DID AN OPERATION PRECEDE DEATH? Yes DATE OF Oct. 29
WAS THERE AN AUTOPSY? No 1930

WHAT TEST CONFIRMED DIAGNOSIS Operative & Clinical symptoms _____ M. D.
(Signed) _____ (Address) 731 Forum St. J. Mo.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Air, IOWA, via auto DATE OF BURIAL Nov. 3, 1930

20. UNDERTAKER Heaton-Belgal & Bowmer ADDRESS 319 S. 10
Funeral Home

