

DEC 20 1930

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

Do not use this space.

35443

1. PLACE OF DEATH

County Buchanan
Township St Joseph
City St Joseph

Registration District No. 35
Primary Registration District No. 1001

File No. 35443
Registered No. 1267
St. Ward)

2. FULL NAME

Emma Smith

(a) Residence. No. 2820 South 19th St. Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED M

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 25 1930

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 25, 1930 to Nov 26, 1930 that I last saw her alive on Nov 25, 1930 and that death occurred, on the date stated above, at 10:30 A. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 11 1888
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 42

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral Apoplexy

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

CONTRIBUTORY (SECONDARY) 1400

9. BIRTHPLACE (CITY OR TOWN) Los Angeles (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

10. NAME OF FATHER Herman Gaekler
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Leadit Germany
12. MAIDEN NAME OF MOTHER Louise Niedemann
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany

8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? Chemical
(Signed) J. H. Gray, M. D.
11/26, 1930 (Address) 725 1/2 Commercial

14. INFORMANT Oscar Smith (Address) 2820, So 19th

*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.

NOV 28 1930 John L. Voh REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Mt. Auburn Nov 27, 1930

20. UNDERTAKER ADDRESS
Fleetsman Funeral Home 1946 Colburn

State of Missouri, County of Buchanan, City of St. Joseph, Missouri, do hereby certify that the above is a true and correct copy of the original as the same appears in the records of the Bureau of Vital Statistics of the Missouri State Board of Health.

THE
STATE
OF
NEW
YORK
IN SENATE
January 15, 1904.

REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 15, 1903.

ALBANY:
J. B. LIPPINCOTT COMPANY,
PRINTERS,
1904.

**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 Buchanan Registration District No. 83- File No.
 Township Primary Registration District No. 1001 Registered No. 1267
 City St. Joseph (No.) St. Ward

2. FULL NAME

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1888

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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 Jan 5 1931 John E. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 25 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:

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.

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

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully verified. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH as fully as possible. OCCUPATION is very important. It should be properly classified. All statements should be true. REGISTER FOR CERTIFICATES UNTIL THEY ARE COMPLETED.

SUPPLEMENTARY

S-3 5443