

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

Do not use this space.

Smith
37018-C
98

PLACE OF DEATH

County Sheeps Registration District No. 677
Township Reels Primary Registration District No. 440.3
City Reels (No. _____) St. _____ Ward _____

2. FULL NAME

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (write the word)

5A. ~~MARRIED~~ WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. E. Coultter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 21, 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
81

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) (STATE OR COUNTRY) Ohio

10. NAME OF FATHER Johnson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER May Herbert

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio

14. INFORMANT Frank Smith
(Address) Reels, Mo.

15. FILED Nov. 24, 1930 Jos. F. Ayers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 20 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1929 to Nov 20 1930 that I last saw her alive on Nov 20 1930 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterio Sclerosis

(duration) _____ 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? W. Smith

(Signed) _____, M. D.

, 19 (Address) Reels 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 DATE OF BURIAL

Picksville Ohio 11-24-30

20. UNDERTAKER

Harry R. Wierman ADDRESS Reels

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.

JAN 21 1931

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CERTIFICATE OF DEATH**

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Smith
File No. **37018-c**

Registered No. **98**
St. _____ Ward _____

1. PLACE OF DEATH
County **Boone**
Township _____
City **Boone** (No. _____)

Registration District No. **677**
Primary Registration District No. **4403**

2. FULL NAME
Mrs Viola F. Couler
(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 **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov 20 1930**

5A. ~~UNMARRIED~~ WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **J. E. Couler**

17. I HEREBY CERTIFY, That I attended deceased from **Aug 1** 19**29** to **Nov 20** 19**30** that I last saw **her** alive on **Nov 20**, 19**30** and that death occurred, on the date stated above, at _____ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Dec. 21. 1848**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
81

Atteria Sclerosis
97 (duration) _____ mos. _____ ds.

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 _____

CONTRIBUTORY (SECONDARY) **9/13**
(duration) _____ yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio**

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

10. NAME OF FATHER **Johnson**

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Ohio**

19. WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER **May Herbert**

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) **W. L. Smith**, M. D.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Ohio**

19 (Address) **Boone Mo**

14. INFORMANT (Address) **Frank Smith Boone, 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.

15. FILED **Nov 24, 1930** **Jos. F. Cizer** REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Hicksville Ohio** DATE OF BURIAL **11-24-30**

20. UNDERTAKER **Harry R. Hines** ADDRESS **Boone**

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.

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