

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

Do not use this space.

1094

1. PLACE OF DEATH

County Jacobs
 Township Galesburg
 City St. Louis (No. _____)

Registration District No. 383
 Primary Registration District No. 2234

File No. _____
 Registered No. 2
 St. _____ Ward _____

2. FULL NAME

Richard G. Smith

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Matie A. Smith</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>8-10-1842</u>		
7. AGE <u>88</u>	YEARS <u>4</u>	MONTHS <u>30</u>
	DAY	If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired
 (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) Oregon to Mo!

PARENTS

10. NAME OF FATHER John Smith
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo
 12. MAIDEN NAME OF MOTHER Matie A. Kneon
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo

14. INFORMANT Belva Marie Smalley
 (Address) Newton Street Mo

15. FILED 2-8-31 H. F. Deo
 REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 10 1934
 17. I HEREBY CERTIFY, That I attended deceased from Jan 9 to Jan 10 3p
 that I last saw him alive on Jan 28, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia

CONTRIBUTORY (SECONDARY) old age
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

19. WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J. E. Jewell, M. D.
 _____, 19____ (Address) New Orleans 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 Barnett School DATE OF BURIAL 1-11-34

20. UNDERTAKER J. J. Moran ADDRESS New Mo

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.

