

**BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

2520
5

FEB 20 1931

1. PLACE OF DEATH
 87 County Rolls Registration District No. 227
 Township Perry Primary Registration District No. 4433
 City Perry (No.) St. Ward

2. FULL NAME Borah Jean 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. 12 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>[Signature]</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>[Signature]</u>		
7. AGE YEARS <u>—</u>	MONTHS <u>—</u>	DAYS <u>12</u>
IF LESS than 1 day, hrs. or min.		
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>[Signature]</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>[Signature]</u> (c) Name of employer <u>[Signature]</u>		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Perry, Mo.</u>		
PARENTS	10. NAME OF FATHER <u>Cloyd Smith</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Perry, Mo.</u>	
	12. MAIDEN NAME OF MOTHER <u>John M. Ball</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>	
14. INFORMANT <u>Cloyd Smith</u> (Address) <u>Perry Mo.</u>		
15. FILED <u>1/31 1931</u> <u>[Signature]</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/31 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1931, to Jan 30, 1931, that I last saw h. alive on 19....., and that death occurred, on the date stated above, at 3-40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia (Broncho)

1078 (duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) 1070 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no. DATE OF

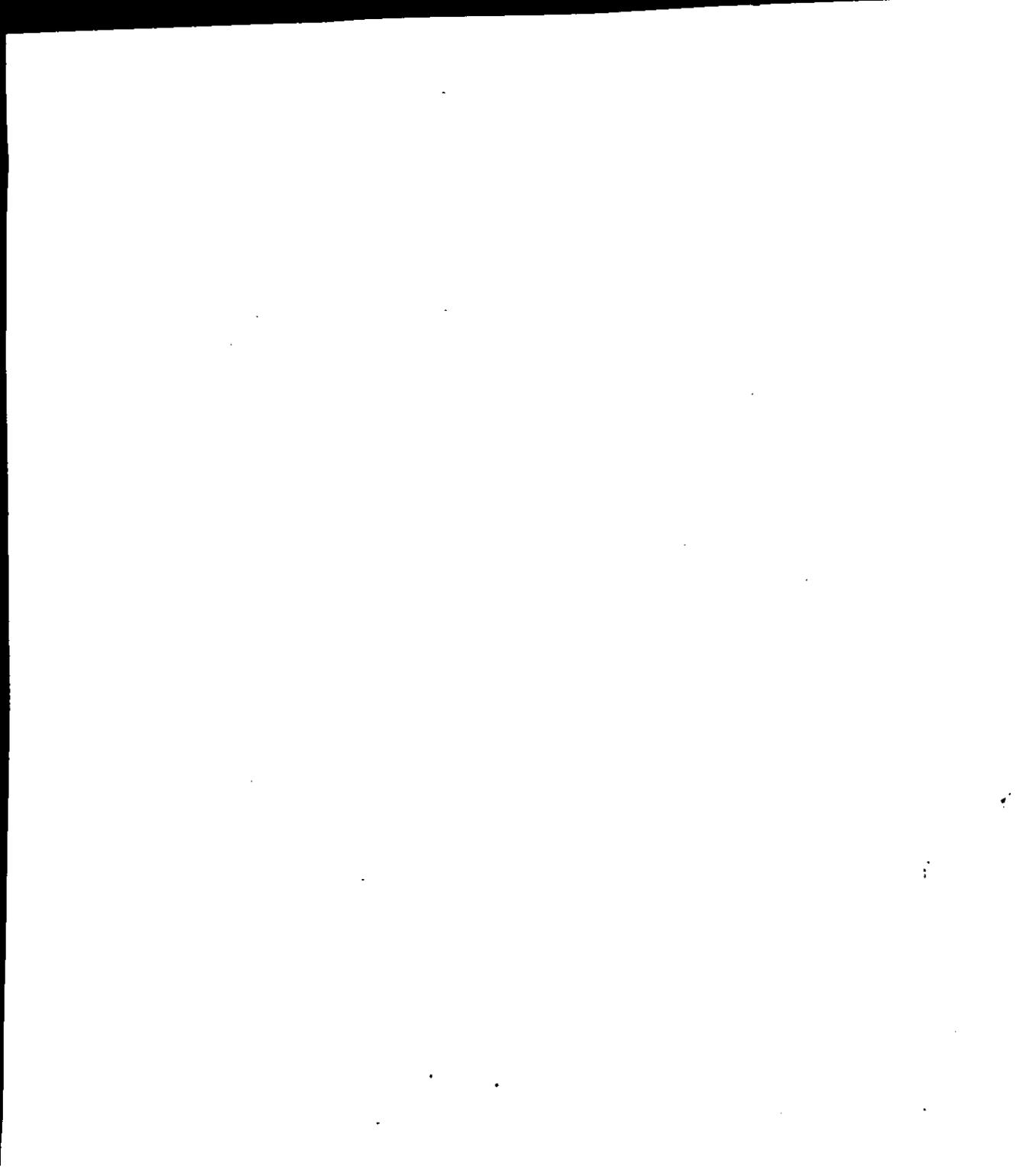
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? [Signature]
 (Signed) [Signature], M. D.

*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 <u>From Chapel Mo.</u>	DATE OF BURIAL <u>Feb 1 1931</u>
20. UNDERTAKER <u>[Signature]</u>	ADDRESS <u>Perry Mo.</u>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If profession, occupation, or cause of death is not stated, it should be so classified. Exact statement of OCCUPATION is very important.



**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 Callao
Township Perry
City Perry (No., St., Ward

Registration District No. 427
Primary Registration District No. 4433

File No. 3-
Registered 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 19 1931

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 12

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 1/31 1931 Geo Routh
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1931

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.....

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

19

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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

S-2520