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

2852

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

PLACE OF DEATH

County St. Louis — Registration District No. 1121 — File No.

Township Carondelet — Primary Registration District No. 2222 B, — Registered No. 42

City Koch (No. Koch Hosp. St. Ward)

FULL NAME SMITH, EDWARD

(a) Residence. No. Municipal Lodging House St. Ward. [illegible]
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred X yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Colored	Single

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single

DATE OF BIRTH (MONTH, DAY AND YEAR) May 22, 1902

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	28	7	25	

OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (CITY OR TOWN) Oklahoma
(STATE OR COUNTRY)

10. NAME OF FATHER Henry Smith

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

12. MAIDEN NAME OF MOTHER Ella Gass

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

INFORMANT Koch Hospital Records
(Address)

FILED 2.2.1931 L. C. Obrock REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 17, 1931

17. I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Jan. 17, 1931, that I last saw him alive on Jan. 17, 1931 and that death occurred, on the date stated above, at 1:55 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

In Koch 23 (duration) 5 Mo. 7 Da. ds.

CONTRIBUTORY (SECONDARY) Unknown

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Unknown

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X Ray & Sputum

(Signed) [illegible], M. D.

1/17/31 (Address) Resident Physician

*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 Calvery Cemetery — DATE OF BURIAL 1-28 1931

20. UNDERTAKER A. Russell Wd Co. — ADDRESS 2732 pine st

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ...St. .....W

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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

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

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

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)

PARENTS

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.
I HEREBY CERTIFY, That I attended deceased from.....
....., 19....., to....., 19
that I last saw h..... alive on....., 19....., an
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) .....yrs.....mos.

CONTRIBUTORY.....
(SECONDARY)

..... (duration) .....yrs.....mos.

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).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICI HOMICIDAL.

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

20. UNDERTAKER	ADDRESS