

MAR 24 1931

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

Do not use this space.

5098

1. PLACE OF DEATH

35 County *Dunklin*
Township *Dalton*
City *by* (In) *St.* (Ward)

Registration District No. *290*
Primary Registration District No. *5406*

File No.
Registered No. *11*
St. Ward)

2. FULL NAME

(a) Residence. No. *1* St. *1* Ward. *1*
(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 (write the word)

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

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

Nov. 11 - 1867

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs.
or min.

*68**2**20*

8. OCCUPATION OF DECEASED

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

Housewife 295

(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)

Dunklin Co. Tenn

10. NAME OF FATHER

Tom Smithwick

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn

12. MAIDEN NAME OF MOTHER

Elizabeth Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn

14.

INFORMANT (Address)

*O. C. Best
Dunklin - Mo.*

15.

FILED

31 1931

H. H. Anderson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 1* 19 *31*

17.

I HEREBY CERTIFY, That I attended deceased from *Jan 25* 19 *31* to *Feb 1* 19 *31* that I last saw him alive on *Feb 1* 19 *31* and that death occurred, on the date stated above, at *7:20* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Influenza**11B*

(duration) yrs. 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?

(Signed)

H. H. Anderson

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

*McGraw**Feb 2* 19 *31*

20. UNDERTAKER

ADDRESS

*McDaniel, Furn. Co.**Dunklin 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.

