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

Do not use this space.

10053

1. PLACE OF DEATH

County: Jackson — Registration District No. 399

Township: Kan — Primary Registration District No. 1082

City: K. C. Mo. (No. 428 No. Oakley St. Ward)

File No.

Registered No.

2. FULL NAME John W. Smith

(a) Residence. No. 428 N Oakley St., 9 Ward.
(Usual place of abode)

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.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 16-1859

7. AGE: Years 78 — Months 7 — Days 2 — If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter 29
(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): N. Y.

PARENTS

10. NAME OF FATHER: no Record

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): no Record 31

12. MAIDEN NAME OF MOTHER: no Record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): no Records

14. INFORMANT: Miss Bessie M. Smith
(Address) 428 No. Oakley

15. FILED 3/18, 1931 M. M. Crowe asst REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Mch-18 1931

17. I HEREBY CERTIFY, That I attended deceased from 2/22, 31, 19__, to 3/18, 1931, that I last saw him alive on 3/18, 1931, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular Heart Disease
92A
135B
(duration) 10 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Cystitis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R H Williams, M. D.
3/18, 1931 (Address) 5400 St John Ave

*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: Mt. Wash Cemetery — DATE OF BURIAL: 3-20 1931

20. UNDERTAKER: Mrs. C. L. Forster — ADDRESS: K. C. 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.

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