

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

Do not use this space.

20219

1. PLACE OF DEATH

98 County St. Charles
Township Franklin
City Linn (No. _____)

Registration District No. 806
Primary Registration District No. 7485

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

2. FULL NAME

George K. Smith
(a) Residence No. Queen City St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 5 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 8/1838

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>92</u>	<u>8</u>	<u>21</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired workman
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Ashland (STATE OR COUNTRY) Ohio

10. NAME OF FATHER Not known

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

12. MAIDEN NAME OF MOTHER Not known

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

14. INFORMANT Capitola Smith (Address) Queen City Mo

15. FILED July 19 31 J. J. Jones REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1931

17. I HEREBY CERTIFY, That I attended deceased from May 22, 1931, to May 29, 1931, that I last saw him alive on May 29, 1931, and that death occurred, on the date stated above, at 10 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy to Heart Liver
95B
13.5B
162 (duration) 2 yrs. mos. ds.

CONTRIBUTORY Sensibility (SECONDARY) (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

19. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS General symptoms
(Signed) B. H. Doe, M. D.
, 19 (Address) Queen City 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 Greenleaf DATE OF BURIAL May 31 1931

20. UNDERTAKER J. J. Jones ADDRESS Queen City 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.

JUL 29 1931

