

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

Do not use this space.

38974

File No. 280
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH
County Calder Registration District No. 213
Township Jefferson Primary Registration District No. 3014
City Jefferson City (No. _____) St. _____ Ward _____

2. FULL NAME Smith White

(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 <u>Male</u>	4. COLOR OR RACE <u>Cal.</u>	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 <u>45</u>	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>				
MOTHER FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
	15. MAIDEN NAME			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL				
PLACE <u>Columbiana</u> DATE <u>Dec 3-31</u>				
19. UNDERTAKER (ADDRESS)				
20. FILED <u>1931</u> <u>3014</u> <u>3014</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-2, 1932

22. I HEREBY CERTIFY, That I attended deceased from Dec 6, 1931, to Dec 2, 1932

I last saw him alive on Dec 2, 1932 Death is said to have occurred on the date stated above, at 10 A. m.

The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis

Other contributory causes of importance: None

Name of operation None Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify None

(Signed) H. M. Rambo, M. D.
(Address) 406 State Cross Hospital

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.

JAN 7 1933

