

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.

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

Do not use this space.

5123

1. PLACE OF DEATH
 25 County Linton Registration District No. 207
 4 Township _____ Primary Registration District No. 4125-
 2 City Plattsburg (No. _____, _____ St. _____ Ward _____)

2. FULL NAME John Smith
 (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. 4 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>Black</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) <u>Sept 18 - 1932</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
		<u>4</u>	<u>26</u>	
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>Mo.</u>				
FATHER	13. NAME <u>Theodie Smith</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>			
MOTHER	15. MAIDEN NAME <u>Sanna Smith</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>			
17. INFORMANT <u>Theodie Smith</u> (ADDRESS) <u>Plattsburg Mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL <u>Colored amt</u> PLACE <u>Plattsburg Mo.</u> DATE <u>Feb 13 1933</u>				
19. UNDERTAKER <u>S. J. W...</u> (ADDRESS) <u>Plattsburg Mo.</u>				
20. FILED <u>2-13 1933</u> <u>C. W. Chastain</u> <u>Deputy Registrar.</u>				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb - 12 1933

22. I HEREBY CERTIFY, That I attended deceased from 6:50 PM Feb - 12 1933 to Feb 12 1933

I last saw him alive on Feb - 12 1933 Death is said to have occurred on the date stated above, at 7 P. m.

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

Date of onset _____

Other contributory causes of importance:
34 34

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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? No
 If so, specify _____
 (Signed) P. M. Steckman, M. D.
 (Address) Plattsburg Mo.

