

535 Bennett

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

Do not use this space.

5398

1. PLACE OF DEATH

34  
35  
5

County Lucas Registration District No. 318  
Township Campanella Primary Registration District No. 2001  
City Youngfield Mo (No. 1133 W. Brower)

File No. ....  
Registered No. 160 St. .... Ward)

2. FULL NAME

Elizabeth Josephine Smith

(a) Residence, No. 1133 W. Brower St. .... Ward. (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>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF <u>W. M. Smith</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 3 1850</u>		
7. AGE	YEARS <u>82</u>	MONTHS <u>7</u>
	DAYS <u>14</u>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>sewer</u>	
	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

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 17 1933

22. I HEREBY CERTIFY, That I attended deceased from Dec 31 1932 to Feb 17 1933  
I last saw him alive on Feb 17 1933 Death is said to have occurred on the date stated above, at 11 P. m.

The principal cause of death and related causes of importance were as follows:  
Pneumonia  
following a fracture  
hip  
Date of onset

Other contributory causes of importance:  
1933

Name of operation ..... Date of operation .....  
What test confirmed diagnosis? Chemical and X-ray Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? fracture Date of injury Dec 31 1932  
Where did injury occur? newspaper house  
(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) M. J. Edwards, M. D.

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>
	13. NAME <u>William Payne</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>
	15. MAIDEN NAME <u>Amelia Goodrich</u>
MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>
	17. INFORMANT (ADDRESS) <u>Mrs Pearl Kelley</u> <u>1133 W. Brower</u>
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Central Lawn</u> DATE <u>2-29-33</u>	
19. UNDERTAKER (ADDRESS) <u>Lloyd W. Fox</u> <u>629 W. Walnut</u>	
20. FILED <u>2-19-33</u> <u>Ralph W. Langston</u> Registrar.	

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.

4-22-25

26518

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Louis Registration District No. 318  
 Township \_\_\_\_\_ Primary Registration District No. 2001  
 City Springfield (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Elizabeth Josephine 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. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX ♀ 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 2 - 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
82 7 14

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) \_\_\_\_\_

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 \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 4-8- 1933 Ralph W. Langston  
 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 17 1933

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Brain, Pulmonary and  
pericardial  
result of fall at  
home  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

**SUPPLEMENTARY**

1860

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

86E5-5