26 1934

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

40891

PLACE OF DEATH

County: Nodaway — Registration District No.: 620 — File No.:

Township: Independence — Primary Registration District No.: 437-6 — Registered No.:

City: (No. , St. Ward)

FULL NAME Juda Ann Smyser

(a) Residence. No. St. Ward. (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	white	

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 9 - 1933

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (CITY OR TOWN) Parnell
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER James W. Smyser

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Greed City
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Marjorie Evelyn Waltz

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

INFORMANT James W. Smyser
(Address) Parnell, Mo.

FILED 12-11, 1933 Alma Campbell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 10 1933

17.
I HEREBY CERTIFY, That I attended deceased from Dec 9, 1933, to Dec 10, 1933, that I last saw h.e.r. alive on Dec 10, 1933, and that death occurred, on the date stated above, at 1:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Premature Birth

(duration) yrs. mos. 1 ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH? At place of Death
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? inspection

(Signed) A. C. Fahrney, M. D.
, 19 (Address) Sheridan 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Parnell Mo	12-11 1933
20. UNDERTAKER	**ADDRESS**
J W Smyser - Father	Parnell

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ... St. .....W

2. FULL NAME .....

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	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	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1

17.
I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19
that I last saw h....., alive on....., 19....., an
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)....., M
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, sta
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL,
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