FEB 27 1934

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

Do not use this space.

1697

1. PLACE OF DEATH
County Knox — Registration District No. 441 — File No.
Township — Primary Registration District No. 4259 — Registered No. 3
City Edina Mo. (No. ..... St. ..... Ward)

2. FULL NAME Cletta May Smith
(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 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-16-1926
7. AGE YEARS 7 MONTHS 3 DAYS 3 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) Green Castle Mo.

FATHER
13. NAME Clifford E Smith
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Green Castle Mo.

MOTHER
15. MAIDEN NAME Madge Jones.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Novinger Mo.

17. INFORMANT (ADDRESS) Art Smith Edina Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Ringo Point DATE Jan-21 1934
19. UNDERTAKER (ADDRESS) Keith M. Hudson Edina Mo.
20. FILED 1-21- 1934 Mrs C.M. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-19, 1934

22. I HEREBY CERTIFY, That I attended deceased from 1-16, 1934, to 1-19, 1934
I last saw her alive on 1-19, 1934 Death is said to have occurred on the date stated above, at 7:30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute obstructive laryngitis	1-16-34
1238	

Other contributory causes of importance:

Name of operation Tracheotomy Date of 1-17-34
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? no
If so, specify
(Signed) Frederick L. Schmitt D.O., M.D.
(Address) Edina, Mo.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Knox — Registration District No.: 441 — File No.: 1697
Township: — Primary Registration District No.: 4259 — Registered No.:
City: Edina (No. ..... St. ..... Ward)

2. FULL NAME: Eletta May Smith

(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): S.

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.

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)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
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 ....., 19.. Mrs C M. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 19, 1934

22. I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19..
I last saw h..... 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:

	Date of onset
Acute obstructive laryngitis	1/16/34
Membranous formation (but now diphtheritically cultured)	

Other contributory causes of importance:

Name of operation: Tracheotomy Date of: 1-17-34
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

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

S-1697