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

NOV 15 1934

Do not use this space.

38229

1. PLACE OF DEATH
County Stoddard
Township Pike
City ..... (No. ..... St. ..... Ward)

Registration District No. 834
Primary Registration District No. 6097

File No. .....
Registered No. 42

2. FULL NAME Milford Leon 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: male
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) Mar 22 - 1931

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
3	6	21	

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) Stoddard County, Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Harlan E Smith
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Effie G Hay
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo
(STATE OR COUNTRY)

14. INFORMANT Effie G. Hay
(Address) Advance Mo

15. FILED 10-17, 1934. J. McKearly REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 13, 1934

17. I HEREBY CERTIFY, That I attended deceased from 10-13-, 1934, to 10-13-, 1934 that I last saw him alive on Oct 10-13, 1934, and that death occurred, on the date stated above, at 8:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Run over by Wagon
(duration) ..... yrs. ..... mos. ..... ds.

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

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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) C R Reynolds, M. D
10-17, 1934 (Address) Advance 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Pleasant Grove Cem, Mo
DATE OF BURIAL: 10-14 1934

20. UNDERTAKER: Loyd S Morgan
ADDRESS: Advance, Mo.

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.