

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

Do not use this space.

**AUG 9 1935**

**24515**

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City *St. Louis* (No. *City Hospital*)..... St. .... Ward)

File No. .... **5897**  
Registered No. ....

**2. FULL NAME**

**Dora Smythe**  
(a) Residence, No. *1921 1/2 Olive St.* Ward *21*  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred *30* 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) *Married*  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *John D. Smythe*  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 20 1875*  
7. AGE YEARS *60* MONTHS *6* DAYS *5* IF LESS than 1 day, .... hrs. or .... min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Work*  
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) *Lensburg Ill*

13. NAME *John D. Hoffman*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

15. MAIDEN NAME *Dora Erb*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Germany*

17. INFORMANT (ADDRESS) *Wm. J. ...*

18. FUNERAL, CREMATION, OR REMOVAL PLACE *Bellefonte Ill* DATE *July 10 1935*

19. UNDERTAKER (ADDRESS) *Wm. J. ...*

20. FILED *9 1935* 19 *J. H. Bredeck* Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7/7 1935*

22. I HEREBY CERTIFY, That I attended deceased from *6/27* to *7/7*

I last saw her alive on *7/7 1935*. Death is said

to have occurred on the date stated above, at *10:50 PM*.  
The principal cause of death and related causes of importance were as follows:

*Diabetic Gangrene Rt Foot*  
*Bronchopneumonia*

Other contributory causes of importance: *5*

Name of operation *Amputation Rt Leg* Date of *7/5/35*

What test confirmed diagnosis? Was there an autopsy? *Yes*

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) *R. B. Senger*, M. D.

(Address) *City*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1000-11-28-35

