

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

7 Do not use this space.

DEC 19 1935

36591

1. PLACE OF DEATH

County Linn

Registration District No. 491

Township Bedford

Primary Registration District No. 4298

City Tracy

File No. _____
Registered No. _____
St. _____ Ward _____

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. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Egna Hyatt

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 7-1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
70 5 20

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) Germany

13. NAME Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

15. MAIDEN NAME Don't Know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

17. INFORMANT (ADDRESS) Mrs Elizabeth Smels

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE 11-29-1935

19. UNDERTAKER (ADDRESS) Kemper Bros

20. FILED 11-28-1935 Mrs Pearl Muck Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-27-1935

22. I HEREBY CERTIFY, That I attended deceased from 11-23-1935, to 11-27-1935

I last saw h. ca. alive on 11-27-1935 Death is said

to have occurred on the date stated above, at 1:30 p.m.

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

Date of onset

Angina Pectoris

Other contributory causes of importance:

[Handwritten signature]

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 _____, 1935

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) H S Hamis M.D., M. D.

(Address) Tracy 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.

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