

MAR 18 1937

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

Do not use this space.

1. PLACE OF DEATH

County FRANKLIN  
Township  
City NEW HAVEN (No. ....) St. .... Ward)

Registration District No. 292  
Primary Registration District No. 4176

File No. 5799

2. FULL NAME MRS. FRED SMITH

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>FEMALE</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>MARRIED</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>FRED SMITH</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>SEPT. 26 1862</u>		
7. AGE YEARS <u>74</u>	MONTHS <u>4</u>	DAYS <u>15</u>
8. Trade, profession, or particular kind of work done, as planer, sawyer, bookkeeper, etc. <u>HOUSE WIFE</u>		If LESS than 1 day, .... hrs. or .... min.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		11. Total time (years) spent in this occupation
10. Date deceased last worked at this occupation (month and year)		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/11 1937

22. I HEREBY CERTIFY, That I attended deceased from 2/2 1937 to 2/11 1937  
I last saw h. .... alive on 2/2 1937 Death is said to have occurred on the date stated above, at 11:00 a.m.  
The principal cause of death and related causes of importance were as follows:

Broncho-Pneumonia

Other contributory causes of importance: 1070

Date of onset

12. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) CLOVER BOTTOM FRANKLIN Co.

FATHER

13. NAME THOMAS MEYER

14. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) FRANKLIN Co.

MOTHER

15. MAIDEN NAME ELISEBETH MEYER

16. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) FRANKLIN Co.

17. INFORMANT FRED SMITH  
(ADDRESS) NEW HAVEN Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE NEW HAVEN CEM. DATE 2-14 1937

19. UNDERTAKER L. G. FERTIG, Son  
(ADDRESS) NEW HAVEN Mo

20. FILED Feb 13 1937 Jeffie Grammerman Registrar (Address) New Haven Mo.

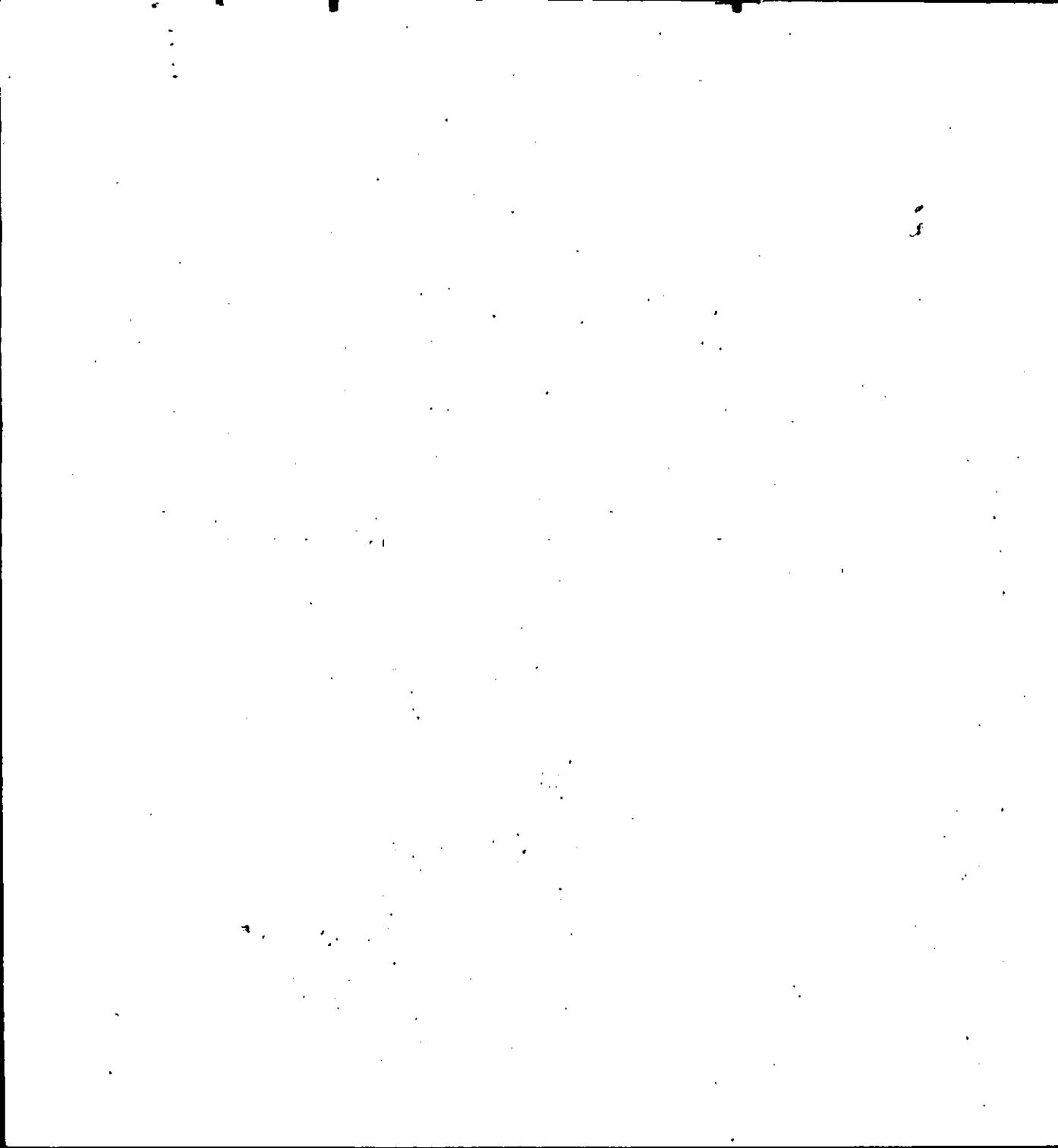
Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 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) L. G. Fertig, M. D.  
(Address) New Haven 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.



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

Do not use this space.

**1. PLACE OF DEATH**

County Franklin

Registration District No. 292

File No. 5-799

Township

Primary Registration District No. 4176

Registered No.

City New Haven (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

**2. FULL NAME**

Mrs. Sophia Smith 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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/11, 1937

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
74 4 13

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

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

Date of onset

Other contributory causes of importance:

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)

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

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 \_\_\_\_\_

19. UNDERTAKER (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) W. J. Eimbeck, M. D.

(Address) New Haven

20. FILED Feb 13 19 37 W. J. Eimbeck Registrar

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.

5-5799