

APR 21 1937

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. *502*
Township *Blue Springs* Primary Registration District No. *4305*
City *Marceline* *Robert Putman Memorial Hospital* (Ward)

File No. *12496*

Registered No. *13*

2. FULL NAME *Mrs. Mary M. 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 *30* 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 *widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Sedney W. Smith*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov 7 1857*

7. AGE YEARS *80* MONTHS *3* DAYS *24* If LESS than 1 day, _____ hrs. or _____ min.

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. *housekeeper*

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) *Marion Co Mo*

13. NAME *Nicholas Henry*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *W. Va.*

15. MAIDEN NAME *Judith Ross*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Do not know*

17. INFORMANT (ADDRESS) *Matt Smith Jefferson City Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Belle Crewe* DATE *Mar 3 - 1937*

19. UNDERTAKER (ADDRESS) *Jas M. Haughlin Marceline Mo.*

20. FILED *3/1* 19*37* *Clara Barnett* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar 1 1937*

22. I HEREBY CERTIFY, That I attended deceased from *Feb 1*, 19*37*, to *Feb 29*, 19*37*

I last saw him *alive on Feb 29*, 19*37*. Death is said to have occurred on the date stated above, at *2:30 am*.

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

Fracture neck of femur Date of onset *Feb 20*

infection *Feb 15*

Other contributory causes of importance: *1860*

Name of operation _____ Date of _____

What test confirmed diagnosis? *Xray* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? *Accident* Date of injury *Jan 30*, 19*37*.

Where did injury occur? *in home* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *Fall*

Nature of injury *Fract neck of femur*

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify _____

(Signed) *Robert Putman*, M. D.
(Address) *Marceline Mo*

WRITE PLAIN IN 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.

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Putman

