

REC'D FEB 25 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County PettisRegistration District No. 668

Township

Primary Registration District No. 3032City Sedalia(No. 1214 S. Mass)File No. 3460Registered No. 468

St.

Ward

2. FULL NAME ELIDA ELIZABETH SMITH(a) Residence, No. 1214 S. Mass St. 1 Ward.Length of residence in city or town where death occurred 50 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 Female4. COLOR OR RACE White5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William Henry Smith6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 18, 1873

7. AGE

YEARS 65MONTHS 0DAYS 19

If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

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) Topeka
(STATE OR COUNTRY) Kansas13. NAME John Hanson14. BIRTHPLACE (CITY OR TOWN) Keokuk Iowa
(STATE OR COUNTRY)15. MAIDEN NAME Elizabeth French16. BIRTHPLACE (CITY OR TOWN) New York City
(STATE OR COUNTRY) New York17. INFORMANT W. R. Smith
(ADDRESS) Sedalia Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Smithton R.O. DATE Jan 9, 193919. UNDERTAKER MELANIE H. BROS.
(ADDRESS) SEDALIA, MO.20. FILED Jan 9, 1939MO. HARRY SMOED
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 7, 1939I HEREBY CERTIFY that I attended deceased from September 19, 1930 to Jan 7, 1939I last saw her alive on Jan 17, 1939. Death is said to have occurred on the date stated above, at 8 P.M.

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

Cerebral Hemorrhage
since 1930

Date of onset

Other contributory causes of importance:

Nephritis and
Hypertension

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? No

If so, specify

(Signed) George Bokling

M. D.

(Address) Sedalia 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.

8261

Date Filed
District File Number
District Health Officer No. 8.

RECEIVED

Ralph E. Baker
2419
Secretary

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 very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE FORWARDED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

3460
Do not use this space.

1. PLACE OF DEATH
(a) County Jefferson Registration District No. 668
(b) Township _____ Primary Registration District No. 3032 Registered No. _____
(c) City Sedalia (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Elida Elizabeth Smith
(a) Residence, No. _____ St. _____
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m
- 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 0 19
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as 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) _____
13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
17. INFORMANT (ADDRESS) _____
18. BURIAL, CREMATION, OR REMOVAL
PLACE _____ DATE _____ 19 _____
19. FUNERAL DIRECTOR (ADDRESS) _____
20. FILED _____ 19 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-7 1939
22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____
- I last saw h. _____ alive on _____ 19____ Death is said to have occurred on the date stated above, at _____ m.
- The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage Date of onset 1939
12/1
- Other contributory causes of importance:
Nephritis & Hypertension
Chronic since 1930
- 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) Card Bohling _____ M. D.
(Address) Sedalia _____

Local Registrar.

