

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

Do not use this space.

29914

1. PLACE OF DEATH

County Sullivan Registration District No. 853  
Township Jackson Primary Registration District No. 6134  
City Aspir (No. 530) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

2. FULL NAME

Henry Eli Smith  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred 60 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male  
4. COLOR OF RACE White  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lidia M. Smith  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 9, 1855  
7. AGE YEARS 84 MONTHS 11 DAYS 7 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 16, 1940  
22. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1940 to Aug 16, 1940  
Last seen alive on Aug 16, 1940. Death is said to have occurred on the date stated above, at 6:00 pm.  
The principal cause of death and related causes of importance were as follows:  
Arteriosclerosis about Aug 10

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

Other contributory causes of importance:  
Chronic nephritis  
arthritis  
Arteriosclerosis  
Arteriosclerosis (Secondary)  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Phys. & Chem. Was there an autopsy? no

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) Hawell, Iowa  
13. NAME  Lorenzo D. Smith  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio  
15. MAIDEN NAME Gippy Gilbert  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

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.

17. INFORMANT (ADDRESS) Mrs. Lydia M. Smith  
18. BURIAL, CREMATION, OR REMOVAL Pollock Camp DATE Aug 18, 1940  
19. UNDERTAKER (ADDRESS) Schwartz  
20. FILED Sept 1, 1940 Cleo Hagan Registrar.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_  
24. Was disease or injury in any way related to occupation of deceased? no, specify \_\_\_\_\_  
(Signed) J. G. Roberts, M. D.  
(Address) Pollock, Mo.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Do not use this space.

RECEIVED

District Health Officer No. 10

District File Number 9-40-1267

Date Filed SEP 10 1941

7-40  
22659

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29914

Registration District No. 832

Primary Registration District No. 6124

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Jackson  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether in this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Henry Eli Smith

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m  
6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 84 Months 11 Days 7  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) Oct 23 1940 (b) O Leo Hagan  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sullivan  
(c) City or town Pollock  
(If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 16  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

