N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sta
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importar

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

Do not use this space.

NOV 25 1940

36479

1. PLACE OF DEATH
County Sylvia
Township Greenbridge
City Gilliam (No. ..... St. ..... Ward)
Registration District No. 744
Primary Registration District No. 4475
File No. .....
Registered No. 9

2. FULL NAME (Unnamed) 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

3. SEX: Male
4. COLOR OR RACE: Black
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 17 1940

7. AGE: YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or 10 min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Bubb
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) Gilliam Mo

FATHER
13. NAME ROBERT HENRY SMITH
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER
15. MAIDEN NAME EVA ODELL PIPER
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Gilliam Mo

17. INFORMANT (ADDRESS) Robert H. Smith Gilliam Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Bernhardt Cem DATE Oct 18 1940

19. UNDERTAKER (ADDRESS) Name

20. FILED Oct 18 1940 J. H. Davidson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 17, 1940

22. I HEREBY CERTIFY, That I attended deceased from Oct 17, 1940, to Oct 17, 1940
I last saw him alive on Oct 17, 1940. Death is said to have occurred on the date stated above, at 10 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Premature birth	Oct 17 1940

Other contributory causes of importance: None

Name of operation ..... Date of .....
What test confirmed diagnosis? — Was there an autopsy? No

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) J. H. Davidson, M. D.
(Address) Gilliam Mo

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11-12-40

S. No. 2B
—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36479

Registration District No. 794 Primary Registration District No. 4475 Registrar's No.

1. PLACE OF DEATH:
(a) County: Saline
(b) City or town: Sellman
(If outside city or town limits, write "RURAL" and name of township)
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(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.

3. (a) PRINT FULL NAME: Manuel Smith
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: M
5. Color or race: B
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased: Oct (Month) 17 (Day) 1940 (Year)

8. AGE: Years | Months | Days | If less than one day: hr. 10 min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Oct 17-1940 (Date received local registrar) J. H. Davidson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17- 1940 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 — Duration
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature J. H. Davidson (M. D. or other)
Address Sellman Date signed

SUPPLEMENTARY