PLACE OF DEATH

County: Buchanan

Township: ~~Tiffany~~

or Village: Agency

or City: (NO. ____ St.: ____ Ward)

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

Registration District No. 80 — File No. 27120

Primary Registration District No. 4048 — Registered No. 25 -

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Bon Tavin Smith

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: white

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Nov (Month) 21 (Day), 1866 (Year)

AGE: 49 yrs. 8 mos. 24 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Agency Mo

NAME OF FATHER: James A Smith

BIRTHPLACE OF FATHER (City or town, State or foreign country): Penn

MAIDEN NAME OF MOTHER: Fannie Boon

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Penn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs Bon Smith

(ADDRESS): Agency

Filed 8/16/16, 191__ RF Duell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug. (Month) 15 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from ____, 191__, to ____, 191__ that I last saw h____ alive on ____, 191__, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Killed by train
~~Time~~ Saw body
August 15th 1916 - 2:30 P.M.

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY): accidental

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Floyd H. Spencer M. D.

Aug. 15, 1916 (Address) Acting Coroner Phone 30 Weston

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Agency

DATE OF BURIAL: Aug 16. 1916

UNDERTAKER: H A Sullins

ADDRESS: Agency Mo

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING 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.

V. S. No. 2.

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.: ..... Ward)

[If death occurred in hospital or institutio give its NAME inste of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Feb 24, 1[illegible] (Month) (Day) (Year)

AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country) Agency

PARENTS

NAME OF FATHER [illegible]

BIRTHPLACE OF FATHER (City or town, State or foreign country) [illegible]

MAIDEN NAME OF MOTHER [illegible]

BIRTHPLACE OF MOTHER (City or town, State or foreign country) [illegible]

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191.... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ....., 191.... (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased fro ....., 191...., to ....., 191.... that I last saw h..... alive on ....., 191.... and that death occurred, on the date stated above, at ..... The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... d

Contributory ..... (SECONDARY)

..... (Duration) ..... yrs. ..... mos. ..... d

(Signed) ..... M.

..... 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, str (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... d

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS