

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

1 PLACE OF DEATH

County
Township
or
Village
or
City *St Louis*

Registration District No. *791* File No. *29498*
Primary Registration District No. *1003* Registered No. *7566*
(NO. *Mo Baptist Sanitarium* St. *17* Ward)

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

2 FULL NAME *Addison H Smith*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Wht* 5 SINGLE MARRIED WIDOWED OF DIVORCED *Widow*
(Write the word)

6 DATE OF BIRTH *Jan 18 1848*
(Month) (Day) (Year)

7 AGE *68* yrs. *6* mos. *20* ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *House work*
(b) General nature of industry business, or establishment in which employed (or employer) *at Home*

9 BIRTHPLACE (City or town, State or foreign country) *St Louis mo.*

PARENTS
10 NAME OF FATHER *A H. Smith*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *New York*
12 MAIDEN NAME OF MOTHER *Sallie Busby*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *St Louis*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Percy A Smith*
(Address) *2517 N 22nd St*

15 Filed *AUG - 3 1916* *Man B Starkloff* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Aug 7 1916*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *7/26* 191*6*, to *8/7* 191*6*, that I last saw her alive on *8/7* 191*6*, and that death occurred, on the date stated above, at *11:30 P.* m.

The CAUSE OF DEATH* was as follows:
Aspirin poisoning
97
1200
81
(Duration) *+* yrs. mos. ds.

CONTRIBUTORY (Secondary) *enteritis*
(Duration) yrs. mos. ds.

(Signed) *W. B. Lindberg*
879 191*6* (Address) *Walden*

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

18 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 *3853 Olive St* if not at place of death?

Former or usual residence *3853 Olive St*

19 PLACE OF BURIAL OR REMOVAL *Calvary* DATE OF BURIAL *Aug 10 1916*

20 UNDERTAKER *Walter Kelly* ADDRESS *2735 Cass*

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.

WALTER KELLY, WITH UNENDING INK—THIS IS A PERMANENT RECORD

