

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

Do not use this space.

22690

1. PLACE OF DEATH

County Jackson Registration District No. _____

Township Kaw Primary Registration District No. _____

City Kansas City (No. Green Hospital)

File No. _____
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

Ode Buckner Smith

(a) Residence No. 3325 Chestnut 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Myrtle L. Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 17-1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49 4 12 = min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Plumber
 (b) General nature of industry, business, or establishment in which employed (or employer) Self.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Quenton Owen Co. Kentucky

PARENTS

10. NAME OF FATHER Amelton Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Mary Ribey

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

14. INFORMANT Mrs O. B. Smith
 (Address) 3325 Chestnut

15. FILED 7-31-1926 M M Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 1926

17. I HEREBY CERTIFY, That I attended deceased from July 25 1926, to July 29 1926, and that I last saw him alive on July 29 8:30 p.m. and that death occurred, on the date stated above, at _____

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Embolic in in Respiratory Center (duration) 1 1/2 hrs.
 CONTRIBUTORY (SECONDARY) Gastric ulcer (duration) 4 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? 3325 Chestnut
 NOT AT PLACE OF DEATH.

DID AN OPERATION PRECEDE DEATH? No DATE OF 7-25-1926
 WAS THERE AN AUTOPEY? No

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) H. B. Jones M. D.
130 (Address) Hammond City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Forest Hill DATE OF BURIAL July 31 1926

20. UNDERTAKER Cedar Bros ADDRESS K. C. 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.

