

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

Do not use this space.

9642

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City *H. Louisiana* (No. *1735th N. 11th*)

File No. *2162*
Registered No.
St. Ward)

2. FULL NAME *Elnora Smith*

(a) Residence. No. *1735th N. 11th* St., *16* Ward.

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Willie Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 5th 1904*

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>22</i>	<i>8</i>	<i>26</i>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mississippi

10. NAME OF FATHER

James Jackson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mississippi

12. MAIDEN NAME OF MOTHER

Mollie Green

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mississippi

14.

INFORMANT

(Address)

Mollie Jackson
1735th N. 11th St

15.

FILED

19

Max C Starckoff
REGISTERED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar 1* 19 *27*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 22* 19 *27*, to *Mar 1* 19 *27*

that I last saw her alive on *Mar 1* 19 *27* and that death occurred, on the date stated above, at *16* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23 yrs

CONTRIBUTORY (SECONDARY)

Not known

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? *No* DATE OF

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *Aspiration*

(Signed) *J. A. Flowers*, M. D.

, 19 *27* (Address) *1711 N. 10th St*

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Farther Nicksen County *Mar 5th 19 27*

20. UNDERTAKER

ADDRESS

A. L. Beal *Lucas Ave,*

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.

