

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.

Oct - 21

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

Do not use this space.

Dr Smith  
 34415

**1. PLACE OF DEATH**  
 County Phelps Registration District No. 677  
 Township \_\_\_\_\_ Primary Registration District No. 4403  
 City Rolla (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 Registered No. 71

**2. FULL NAME** Mrs Josephine M. Smail  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** Female    **4. COLOR OR RACE** white    **5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)** widowed

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Dec. 10, 1849

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>78</u>	<u>10</u>	<u>11</u>	

**8. OCCUPATION OF DECEASED**  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) at home  
 (c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Greenville, Indiana

**10. NAME OF FATHER** John G. Stuart

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** Guilford Co North Carolina

**12. MAIDEN NAME OF MOTHER** Elizabeth Caldwell

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** Standscocks Ind.

**14. INFORMANT** Emma Smail  
 (Address) Rolla Mo.

**15. FILED** Dec 28 1928 Geo. F. Ayers  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Oct 21 1928

**17. I HEREBY CERTIFY, That I attended deceased from** last 2 or 3 years 19\_\_\_\_  
 that I last saw her alive on Oct 21 1928, and that death occurred, on the date stated above, at 4 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Myocarditis  
 (duration) yrs. 1 mos. da.

**CONTRIBUTORY (SECONDARY)** Chronic Nephritis  
 (duration) about 3 yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH: \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_

**WHAT TEST CONFIRMED DIAGNOSIS**  
 (Signed) M. S. Smith, M. D.  
 (Address) \_\_\_\_\_, 19\_\_\_\_

\*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.

<b>19. PLACE OF BURIAL, CREMATION, OR REMOVAL</b> <u>Rolla Cemetery</u>	<b>DATE OF BURIAL</b> <u>19</u>
<b>20. UNDERTAKER</b> <u>Harry R. McCaw</u>	<b>ADDRESS</b> <u>Rolla Mo.</u>

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Shelby  
Township Polla  
City Polla (No. ....)

Registration District No. 677  
Primary Registration District No. 4403

File No. ....  
Registered No. 71  
St. .... Ward

**2. FULL NAME**

Mrs Josephine M. Smail  
(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

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

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

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

**8. OCCUPATION OF DECEASED**

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

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED Jan 14 1928

Geo. F. Ayers  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 21 1928

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19..... that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 19 (Address)

\*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

20. UNDERTAKER

ADDRESS

Oct. 23 1928

information should be fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state USUAL PLACE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-34415