JAN 25 1929

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

Do not use this space. 2662

~~41817~~

1. PLACE OF DEATH
County New Madrid — Registration District No. 604 — File No. 6
Township " " " — Primary Registration District No. 5802 — Registered No.
City ..... (No. 1 ..... St. ..... Ward)

2. FULL NAME Minnie Smith
(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) — — 1885

7. AGE Years 44 Months Est. Days — If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) St. Joseph
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Ed. Simmons
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Rockford
(STATE OR COUNTRY) Va
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) " "
(STATE OR COUNTRY) " "

14. INFORMANT John J. Smith
(Address) New Madrid

15. FILED 1/8/1929 W. O'Banna
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 — 8 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1929, to Jan 8, 1929 that I last saw her alive on Jan 4, 1928, and that death occurred, on the date stated above, at 2 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia - Sobor

108 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

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? —
(Signed) W. L. [illegible], M. D
1/8/1929 (Address) New Madrid

*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 Dawson Cem — DATE OF BURIAL 1-8 1929

20. UNDERTAKER Richards Ind Co — ADDRESS New Madrid

72
0
0
235
1
2
31

...supplied. AGE should be stated EXACTLY. PHYSICIANS should state ...may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be carefully [illegible] AGE should be stated EXACTLY. PHYSICIANS sh[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified [illegible] statement of OCCUPATION is very im[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified [illegible]

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH
County New Madrid Registration District No. 604 File No. 6
Township " " Primary Registration District No. 5802 Registered No.
City (No. , St. Ward)

2. FULL NAME Minnie Smith
(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unk. 1885

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
44	Unk.		

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)

PARENTS
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 1/8/1929 W O Bannon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/8/1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

5-2662