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

Do not use this space.

39322

1. PLACE OF DEATH
County Saline
Township Marshall
City ..... St. ..... Ward)

Registration District No. 796
Primary Registration District No. 3038

File No. .....
Registered No. 172

2. FULL NAME Clarence C 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 23 yrs. 0 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Single

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

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
56	6	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Stanberry
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Ruben P Smith
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Stanberry
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER D K.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) D K.
(STATE OR COUNTRY)

14. INFORMANT Hospital Record
(Address) Marshall Mo

15. FILED 11-20, 1929 Mrs. John H. McGuire
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 14 1929

17. I HEREBY CERTIFY, That I attended deceased from March 5, 1928, to Nov 14, 1929 that I last saw him alive on Nov 14, 1929, and that death occurred, on the date stated above, at 6:15 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchopneumonia
107A
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) 100A
(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? Clinical

11/14, 1929 (Signed) H B Maples, M. D.
(Address) Marshall

*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 Albany Mo
DATE OF BURIAL Nov 16 1929

20. UNDERTAKER L. R. Vandiver
ADDRESS Marshall Mo.

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

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5
7
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2

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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: Saline — Registration District No.: 796 — File No.:
Township: — Primary Registration District No.: 3038 — Registered No.: 172
City: Marshall (No. , St. Ward)

2. FULL NAME: Clarence C 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-16-1873

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
56	6	28	

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 11-20 19 29 Mrs. John H McGuire
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 14 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

N. B. — Every item of information should be carefully supplied. All 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.

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

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