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

Do not use this space.

28896

1. PLACE OF DEATH

County Sullivan — Registration District No. 854

Township ~~[illegible]~~ Bowman — Primary Registration District No. 4520

City Osgood (No. ..... St. ..... Ward)

File No. .....

Registered No. 7

2. FULL NAME William B. 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: M

4. COLOR OR RACE: W

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 25 1850

7. AGE: Years 80 — Months 1 — Days — If LESS than 1 day, ... hrs. or ..... min.

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) .....
(STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER Samuel D. Smith

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

12. MAIDEN NAME OF MOTHER Mary A. Gaunce

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

14. INFORMANT Noble Smith
(Address) Osgood Mo

15. FILED Aug 26 1930 B L Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 25 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1930, to Aug 25, 1930 that I last saw him alive on 8-8, 1930, and that death occurred, on the date stated above, at 8 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myxa Cardiitis

93C

1MB

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Diarrhoea

(duration) ..... yrs. ..... mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? was

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) U C Weston, M. D

8-26, 1930 (Address) Galt 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Union Grove — DATE OF BURIAL: 8-26 1930

20. UNDERTAKER: H. J. Martin — ADDRESS: Harris 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.

THIS IS A PERMANENT RECORD