

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

8600

1. PLACE OF DEATH

County Wayne Registration District No. 890
Township St. Francis Primary Registration District No. 4639
City Greenwell (No. _____) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Mary Francis 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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/9 1931

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

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1929, to Feb 9, 1931, that I last saw h. alive on _____, 19____, and that death occurred, on the date stated above, at 1:15 A. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 4, 1857

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of third class

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 3 5

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

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. (1)
DID AN OPERATION PRECEDE DEATH? yes DATE OF Oct 15, 1930
WAS THERE AN AUTOPSY? no

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

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) Dr. C. G. Myers, M. D.
, 19____ (Address) Greenwell Mo

10. NAME OF FATHER John Roberts

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

12. MAIDEN NAME OF MOTHER Emilia Gordon

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

14. INFORMANT A. M. Smith (Address) Greenwell Mo

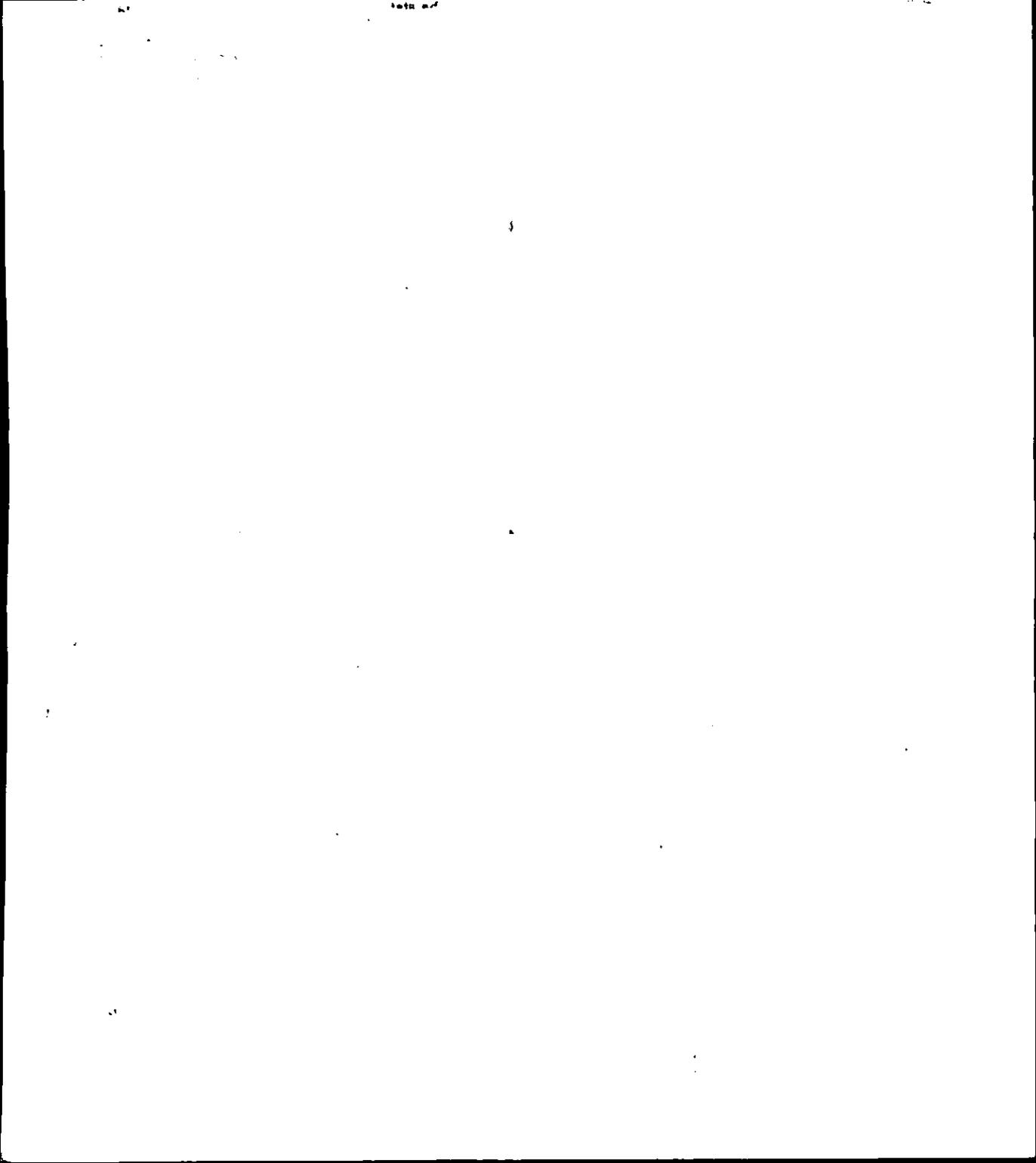
15. FILED 2/10 1931 C. S. Humphreys REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wallas Cem DATE OF BURIAL 2/10 1931

20. UNDERTAKER Gish and Co. ADDRESS Judgment

n. 2.—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.

ADD 97 108



**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 Wayne Registration District No. 890 File No.
 Township Greenville Primary Registration District No. 4039 Registered No.
 City Greenville St. Ward)

2. FULL NAME Mary Francis 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED wid
(write the word)

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.

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. FILER, 19... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/9 19 31

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Thrombosis
Chronic
of face - Tubercular

CONTRIBUTORY (SECONDARY) 52
 (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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 No. 2. 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.

SUPPLEMENTARY

5-8600