

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

Do not use this space.

7094

1. PLACE OF DEATH

105 County Sullivan
2 Township Peru
3 City Green City, Mo. (No. _____)

Registration District No. 849

Primary Registration District No. 4575

File No. _____
Registered No. 4
St. _____ Ward _____

2. FULL NAME Emma Lois 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 8/1866

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	67	11	20	

8. OCCUPATION OF DECEASED 235
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) on farm
(c) Name of employer retiree

9. BIRTHPLACE (CITY OR TOWN) Iowa
(STATE OR COUNTRY)

10. NAME OF FATHER L.T. Dillinger

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

12. MAIDEN NAME OF MOTHER Mary Davis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Marion Co. Mo.
(STATE OR COUNTRY)

14. INFORMANT James Smith
(Address) Green City Mo.

15. FILED Mar 9, 1932 Miss Kate Lane
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-28-1932

17. I HEREBY CERTIFY, That I attended deceased from Feb 19, 1932 to Feb 28, 1932
that I last saw her alive on Feb 19, 1932, and that death occurred, on the date stated above, at X m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of the Liver
46 E (duration) Don't know yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 46 E (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) Ross H. Shepler, M. D.
. 19 (Address) Green City 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 St. Olivet DATE OF BURIAL 2-29-1932

20. UNDERTAKER Glenn E. Kew ADDRESS Green City 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 OCCURRENCE is very important. MAR 5 1932

