

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.

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

Do not use this space.

MAR 24 1934

270

4071
238

1. PLACE OF DEATH

County Bryan Registration District No. _____
 Township Washington Primary Registration District No. 1001
 City St. Joseph (No. State Hospital #2) St. _____ Ward _____

2. FULL NAME

Nancy Smith
 (a) Residence, No. State Hospital #2 St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 3 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Unknown Smith.</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov 3, 1861</u>		
7. AGE YEARS <u>82</u>	MONTHS <u>3</u>	DAYS <u>22</u> If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown Illinois</u>		
FATHER	13. NAME <u>Unknown</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
MOTHER	15. MAIDEN NAME <u>Unknown</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>	
17. INFORMANT <u>Wood Records #</u> (ADDRESS) <u>St. Joseph, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Kirkville, Mo.</u> DATE <u>March 1, 1934</u>		
19. UNDERTAKER <u>E. P. Sidelafaden</u> (ADDRESS) <u>603 South 10th Street</u>		
20. FILED <u>2-28-34</u> <u>John P. Bender</u> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) February 25, 1934

22. I HEREBY CERTIFY, That I attended deceased from July 1931 to February 25, 1934
 I last saw him alive on February 25, 1934. Death is said to have occurred on the date stated above, at 9:30 a.m.
 The principal cause of death and related causes of importance were as follows:
Chronic myocarditis Date of onset Indefinite
930, 10/20/11
 Other contributory causes of importance:
Bronchitis Feb 23 '34

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Clifford Smith M. D.
 (Address) State Hospital #2 St. Joseph, Mo.

