LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

DEC 28 1936

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

41842

DEC 28 1936

1. PLACE OF DEATH

County: Mcdonald — Registration District No.: 965 — File No.: 172

Township: Elk River — Primary Registration District No.: 5-692 — Registered No.: 45

City: Noel (No. ..... St. ..... Ward)

2. FULL NAME: James W. Smith

(a) Residence (Usual place of abode) No. ..... St., ... Ward. ..... (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: Male

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: Flora Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 24 1881

7. AGE: Years 55 — Months 6 — Days 23 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Oil Agent

(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): Mound City Kansas

PARENTS

10. NAME OF FATHER: W. S. Smith

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

12. MAIDEN NAME OF MOTHER: E. Mattox

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

14. INFORMANT: Mrs A. K. Johnson (Address) Sulphur Spg Ark

15. FILED 11/16 1936 — REGISTRAR: K C Alexander

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 11-14 1936

17. I HEREBY CERTIFY, That I attended deceased from 10-9, 1936, to 11-14, 1936 that I last saw him alive on 11-14, 1936, and that death occurred, on the date stated above, at 8:46 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Broncho-pneumonia (Double)

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

CONTRIBUTORY (SECONDARY): Acute Tonsillitis, Pleurisy, Acute Arthritis (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? Physical exam

(Signed) R. E. Warmack, M. D.

, 19 (Address) Southwest 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Marshall Cemetery — DATE OF BURIAL: Nov 17 1936

20. UNDERTAKER: J. T. Dunn — ADDRESS: Sulphur Spgs Ark

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.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(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)

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)

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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.