

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

**17910**

Do not use this space.

1. PLACE OF DEATH **3**

(a) County Buchanan Registration District No. 85

(b) Township 0 Primary Registration District No. 1001 Registered No. 554

(c) City St. Joseph Mo (d) Street No. State Hospital #2 St.

(e) Length of residence in city or town where death occurred 530 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Maude Bronson Smith

(a) Residence, No. Independence Mo St.  Independence Mo

(Usual place of abode, if no street address, with county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX 2 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF (None)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) UNKNOWN

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.

Est. 51 ? ?

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as 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) Mo. 0

FATHER

13. NAME Unknown 9

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 9

MOTHER

15. MAIDEN NAME Unknown 1

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) State Hospital Records St. Joseph Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE State Hospital #2 DATE 5-20-1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN & SON, INC. St. Joseph, Mo.

20. FILED May 20 1940 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-14-1940

22. I HEREBY CERTIFY, That I attended deceased from 7-26-1924 to 5-14-1940

I last saw her alive on 5-13-1940 Death is said to have occurred on the date stated above, at 7:30 a.m.

The principal cause of death and related causes of importance, were as follows:

Valvular Sclerosis with Chronic Endocarditis. Date of onset Indy

Other contributory causes of importance: 92 W

Name of operation None Date of 44

What test confirmed diagnosis? Blue Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? No 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 None

Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify None

(Signed) R. B. Miles M. D.

85 (Address) State Hospital #2

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

*Body not Embalmed.*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body, whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**