OCT 28 1930

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

Do not use this space.

File No. 29722

Registered No. .....

1. PLACE OF DEATH
County Harrison Registration District No. 340
Township White Oak Primary Registration District No. 6476
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Samuel A 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. ..... da. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... da.

PERSONAL AND STATISTICAL PARTICULARS

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

5a. If MARRIED, WIDOWED, OR DIVORCED — HUSBAND OF (OR) ~~WIFE OF~~: Fannie Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 3-4-1873

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	57	6	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(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) Harrison Co Mo

PARENTS

10. NAME OF FATHER Edward Smith
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Frances Clayton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Virginia

14. INFORMANT Edgar Clayton
(Address) Bethany Mo

15. FILED Oct 10, 1930 Ken Wood REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 9-16 1930

17. I HEREBY CERTIFY, That I attended deceased from 9 P.M. Sept 16, 1930, to 9 A.M. Sept 16, 1930 that I last saw ..... alive on Sept 15, 1930 and that death occurred, on the date stated above, at 3:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary Occlusion
94 A
(duration) 8 hours

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... da.

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) [illegible], M. D
9/16, 1930 (Address) Bethany 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: Miriam Cemetery — DATE OF BURIAL: 9-17 1930

20. UNDERTAKER: S M Sears — ADDRESS: Bethany 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 OCCUPATION is very important.