

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

Do not use this space.

2957

1. PLACE OF DEATH

County St. Francois Registration District No. 775 File No. _____
 Township Pepper Primary Registration District No. 0027 Registered No. 11
 City East of Bonne Terre, Mo. St. _____ Ward _____

2. FULL NAME Andrew LeRoy Smith

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 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. (If nonresident give city or town and State)

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 Maudie Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July-18-1897

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
35 6 4

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) St. Francois Co.
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Richard Jackson Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) St. Francois, Mo.

12. MAIDEN NAME OF MOTHER Elba May Morris

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) St. Francois, Mo.

14. INFORMANT Myrtle J. Turley
 (Address) East of Bonne Terre, Mo.

15. FILED 1/27/33 T. A. Son
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 22 19 33

17. I HEREBY CERTIFY, That I attended deceased from 1-21-33, 19 33, to 1-22, 19 33, that I last saw h. l. a. alive on Jan 23, 19 33, and that death occurred, on the date stated above, at 3:25 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ruptured Gastric ulcer

CONTRIBUTORY (SECONDARY) 1170

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: Home

DID AN OPERATION PRECEDE DEATH: no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS: Exam

(Signed) C. H. Appleberry M. D.

1/24, 1933 (Address) Flas River, 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

Marvin Chapel

DATE OF BURIAL

1/24 1933

20. UNDERTAKER

Bertram Wells

ADDRESS

Bonne Terre, 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.

