

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.

48-A

MAR 24 1934

1. PLACE OF DEATH
 County Audrain Registration District No. 24-
 Township Louise Primary Registration District No. 4019
 City St. Louis (No. 502) Registered No. 83
 St. St. Louis Ward 5

2. FULL NAME Mattie Bell Clement
 (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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>M. Clement</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 27-1874</u>		
7. AGE <u>59</u>	YEARS <u>3</u>	MONTHS <u>24</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>at home</u>		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>same</u>		
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Callaway Co mo</u>		
13. NAME <u>Miss Rodgers</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Texas</u>		
15. MAIDEN NAME <u>Amie Gillison</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Texas</u>		
17. INFORMANT <u>Mrs. Charles Smallfield</u> <u>St. Louis City Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Mary's Church</u> DATE <u>1-22-34</u>		
19. UNDERTAKER (ADDRESS) <u>Wells & Co. Inc.</u>		
20. FILED <u>Feb-24-1934</u> <u>Mary C. Jacob</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-20-1934

22. I HEREBY CERTIFY, That I attended deceased from 11-27-1933 to 1-20-1934
 I last saw him alive on 1-20-1934 Death is said to have occurred on the date stated above, at 10 m.
 The principal cause of death and related causes of importance were as follows:
Carcinoma of uterus
 Date of onset _____

Other contributory causes of importance:
no

Name of operation no Date of _____
 What test confirmed diagnosis? Spinal fluid 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) A. E. Smith, M. D.
 (Address) Reish Hill, mo

