

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

3150
 Do not use this space.

1112

1. PLACE OF DEATH
 (a) County Jasper Registration District No. 417
 (b) Township Walt City Primary Registration District No. 3021 Registered No. 3
 (c) City Walt City (d) Street No. 831 N. WILSON St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. 7 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Shirley Deanna Smith 530
 (a) Residence, No. 831 N. Wilson St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3/SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 2, 1937
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
7 0 0 0 0
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child
 9. Industry or business in which work was done, as saw mill, bank, etc. Child
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 3, 1938
 22. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1937, to Jan 3, 1938.
 I last saw her alive on Jan 20, 1938. Death is said to have occurred on the date stated above, at 12:40 a.m.
 The principal cause of death and related causes of importance were as follows:

Pneumonia
 PRIOR TO 2-25-37
 Date of onset
 Other contributory causes of importance:
107

12. BIRTHPLACE (CITY OR TOWN) Walt City (STATE OR COUNTRY) Missouri
 FATHER 13. NAME Alvin M. Smith
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 MOTHER 15. MAIDEN NAME Josephine Gibson
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 17. INFORMANT (ADDRESS) Alvin M. Smith
Walt City, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Cartersville Cem DATE 1/4, 1938
 19. FUNERAL DIRECTOR (ADDRESS) Walt City Burd Co.
Walt City, Mo.
 20. FILED AJN 4. 38, 19 1212 Local Registrar

Name of operation _____ Date of _____
 What test confirmed diagnosis? CLINICAL 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) P. M. Stormont, M. D.
Walt City, Mo.
 377 (Address)

CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY UNDERSTOOD

107a

RECEIVED

FEB 25 1938

BUREAU OF VITAL STATISTICS
MO. STATE BOARD OF HEALTH

STATEMENT BY LICENSED EMBALMER

I, Clayton Johnston, Licensed Embalmer No. 3,922

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Clayton Johnston

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 3,922

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

(a) County Jasper Registration District No. 417
(b) Township _____ Primary Registration District No. 3021 Registered No. _____
(c) City Webb City (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Shirley Deana Smith
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (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. 7 1

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 3/15 38 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 3 1938

22. I HEREBY CERTIFY, That I attended deceased from 19____ to 19____ I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m. The principal cause of death and related causes of importance were as follows:

Broncho Pneumonia

No complications

Date of onset Feb 15 1938

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____ If so, specify _____ (Signed) R. M. Starnmont M. D. (Address) Webb City Mo

SUPPLEMENTAL

7938

S-3150