

REC'D MAY 24 1938

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

16011

Do not use this space.

1. PLACE OF DEATH *Shannon*
 (a) County.....*Shannon* Registration District No. *824*
 (b) Township.....*Shannon* Primary Registration District No. *6076*
 (c) City..... (d) Street No.
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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 *John Smith 530*
 (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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Sarah A. Smith*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 18-1884*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
84 1 18

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

FATHER 13. NAME *Joseph Smith*

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

MOTHER 15. MAIDEN NAME *McKinnon*

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

17. INFORMANT (ADDRESS) *Frank Smith Eunice Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Alley Cemetery* DATE *4-7-38*

19. FUNERAL DIRECTOR (ADDRESS) *None*

20. FILED *4-6-38* 19*38* *Frank Boyd Mo* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Apr 6 - 1938*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 1 - 1928*, to *Apr 6 - 1938*

Last saw him alive on *Apr 1 - 1938*. Death is said to have occurred on the date stated above, at *3:30 p.m.*

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

Cardiovascular disease Date of onset

Other contributory causes of importance: *15 P.T.*

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) *Frank Boyd*, M. D.

(Address) *Eunice Mo*

WRITE 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.

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

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

..... L. E.

No. or by, Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.

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.)