

REC'D AUG 8 1938

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

24246  
Do not use this space.

1. PLACE OF DEATH  
(a) County Jackson Registration District No. 399  
(b) Township Ray Primary Registration District No. 1002 Registered No. 2751  
(c) City Ray, Mo. (d) Street No. General Hospital St.  
(e) Length of residence in city or town where death occurred yrs. mos. ds. 11 How long in U. S. of foreign birth? yrs. mos. ds.  
2. PRINT FULL NAME Nattie Smith  
(a) Residence, No. 1825 E. 11th 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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF       
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-16-1899  
7. AGE YEARS 38 MONTHS 8 DAYS 20 If LESS than 1 day, hrs. or min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
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) Ark.  
13. NAME Unknown  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
15. MAIDEN NAME Unknown  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
17. INFORMANT (ADDRESS) Record Clerk General Hospital  
18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge DATE 7/8/38  
19. FUNERAL DIRECTOR (ADDRESS) Kenny Fun Home 1905 E. 14  
20. FILED 7-8 1938 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-5 1938  
22. I HEREBY CERTIFY, That I attended deceased from 5-29, 1938, to 6-5, 1938. I last saw her alive on 6-5, 1938. Death is said to have occurred on the date stated above, at 3:15 A.M.  
The principal cause of death and related causes of importance were as follows:  
Pulmonary Tuberculosis (Bilateral)  
Other contributory causes of importance: n.s.  
Name of operation Clinical Date of 7-8  
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) A. C. Daniel M.D.  
(Address) General Hospital

V. S. NO. 2. 90M-50-37 I X12004  
 MARGIN RESERVED FOR BINDING  
 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.)**