

REC'D SEP 14 1938

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

29575
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 605
 (b) Township Orms Primary Registration District No. 4359 Registered No. _____
 (c) City _____ (d) Street No. _____ 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

Genevieve Chism 211
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (Write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-12, 1938

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

22. I HEREBY CERTIFY, That I attended deceased from 8-1, 1938, to 8-12, 1938
 I last saw her alive on 8-11, 1938. Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 1, 1956

to have occurred on the date stated above, at 8 a. m.
 The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 11 11

Lobar pneumonia Date of onset _____

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 _____

Other contributory causes of importance: 104

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) La

13. NAME Brook Chism

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

15. MAIDEN NAME Leith Colvin

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

17. INFORMANT (ADDRESS) Oscar Colvin
Lilbourn Rt 1

18. BURIAL, CREMATION, OR REMOVAL PLACE Mounts DATE 8-13, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Phil Bero
812 28th St

20. FILED 8/12 1938 Dr. George Justice
Local Registrar.

Name of operation clinical Date of 76
 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 Death resulted

(Signed) Parson, M.D.
 (Address) 534

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,,
....., or by,
Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.