

REC'D OCT 19 1938

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

Do not use this space.

1. PLACE OF DEATH
 County Cape Girardeau 1 Registration District No. 128
 Townshp Apple Creek Primary Registration District No. 5176B
 City Oak Ridge (No. _____) St. _____ Ward _____

2. FULL NAME Mollie L. Smith 530
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 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.

File No. 31902
 Registered No. _____

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 11, 1876

7. AGE YEARS 62 MONTHS 2 DAYS 19 IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housekeeper
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) Jan. 1, 1938 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Oak Ridge Mo. 0
 13. NAME W. L. Turner 1
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia 0
 15. MAIDEN NAME Mary Bollinger
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bedgorthville Mo.

MOTHER
 17. INFORMANT John J. Turner
 (ADDRESS) Oak Ridge Mo.
 18. BURIAL, CREMATION OR REMOVAL PLACE Oak Ridge Mo. DATE 4 19
 19. UNDERTAKER Crabroff Miller
 (ADDRESS) Springfield Mo.
 OCT 10 1938
 20. FILED Laura S. Sible
 19 _____ Registrar.

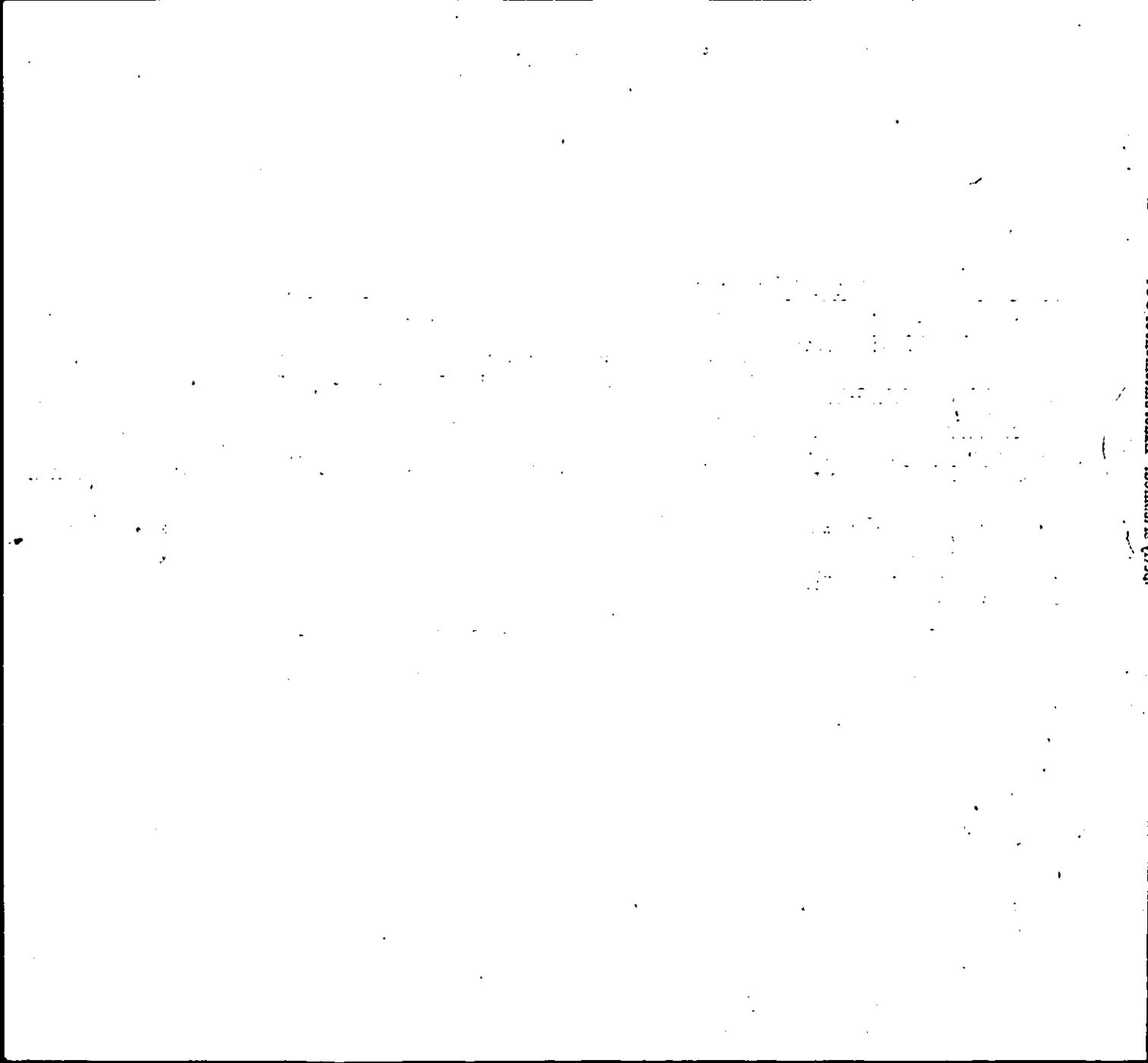
21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-30 1938

22. I HEREBY CERTIFY, That I attended deceased from 9-26, 1938, to 9-30, 1938
 I last saw her alive on 9-30, 1938. Death is said to have occurred on the date stated above, at 2 A. m.
 The principal cause of death and related causes of importance were as follows:
Angina pectoris - followed by auricular flutter
 Other contributory causes of importance: g40
1. - Debility as result of long illness from typhoid
2. - Arteriosclerosis
 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? no
 If so, specify _____
 (Signed) Albert M. Estep, M. D.
Jacobson (Address)

N.B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

31902

Do not use this space.

1. PLACE OF DEATH
 (a) County Cape Girardeau Registration District No. 128
 (b) Township Apple Creek Primary Registration District No. 5176 B
 (c) 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 Mollie L. Smith
 (a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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.
62 2 19

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 Oct-2 1938

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Oct-10- 1938 Laura O. Gabe Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-30 1938

22. I HEREBY CERTIFY, That I attended deceased from 19... to 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:

Date of onset

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) Albert M. Ester, M. D.
 (Address) Jackson

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

