

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

Do not use this space.

36334

1. PLACE OF DEATH

County Montgomery
Township Keokuk
City Keokuk (No.)

Registration District No. 595
Primary Registration District No. 4353

File No. 20
Registered No. 20
St. Ward

2. FULL NAME

Celestine Celina Smith

(a) Residence, No. St. Ward.

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W. C. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (with the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 30 - 1872

7. AGE YEARS 66 MONTHS 1 DAYS 15 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Sewing Room

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Relief

10. Date deceased last worked at this occupation (month and year) 1905 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marland, Mo

13. NAME Benjamin Marshall

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis, Mo

15. MAIDEN NAME Elizabeth Liegen

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

17. INFORMANT (ADDRESS) Henry Smith, Keokuk, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Keokuk, Mo DATE 10-15-38

19. UNDERTAKER (ADDRESS) W. B. Miller, Keokuk, Mo

20. FILED Oct 16, 1938 Mrs. Mike McDermott, Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 15, 1938

22. I HEREBY CERTIFY, That I attended deceased from March 1, 1939 to Oct 15, 1938

last saw her alive on Oct 14, 1938 Death is said to have occurred on the date stated above, at 3 A. M.

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

Carcinoma (Liver) Date of onset 1 yr

Other contributory causes of importance:

fracture of hip
intra capsular 4 mos

Name of operation None Date of
What test confirmed diagnosis Clinical 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) A. A. Martwick, D. O.
(Address) Waller, Mo

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.

WHITE PRINTED WITH CUTTING MARKS THIS IS A PERMANENT RECORD

1994

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

36334
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1. PLACE OF DEATH

(a) County Montgomery Registration District No. 595
 (b) Township _____ Primary Registration District No. 1358 Registered No. 20
 (c) City Wellsville mo (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 Celestine Eulia 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 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.
16 1 15

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

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 15, 1938

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

I last saw h. _____ 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:

Carcinoma liver Date of onset _____
Fracture R. Hip 196
Intra Capsular

Other contributory causes of importance:

Was subject to loss of balance for a period of one year before death - Fall 1937

Name of operation _____ Date of _____ 38

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? Fall Date of injury Oct 11, 1938

Where did injury occur? Wellsville mo (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury loss of balance - Fall

Nature of injury Intra Capsular Fracture

24. Is disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) W. Mark Reich M. D.

(Address) Wellsville mo

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.

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

