

1938 JAN 17 1939

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

44361
Do not use this space.

1. PLACE OF DEATH

(a) County St. Clair 2 Registration District No. 769
(b) Township Goodwell 1 Primary Registration District No. 6015
(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.

Registered No. 11

2. PRINT FULL NAME

(a) Residence, No. 531 Nathan B Smith St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 8 - 1845
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 93 4 0
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
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) 1918 11. Total time (years) spent in this occupation 52
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ry 1
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 My Clara Smith
(ADDRESS) Edwards Spring 20014
18. BURIAL, CREMATION, OR REMOVAL PLACE Mount Cen DATE Aug-9-1938
19. FUNERAL DIRECTOR F. B. Goodrich
(ADDRESS) Box 202 no
20. FILED DEC 10 1938 Mrs J W Richardson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 8 1938
22. I HEREBY CERTIFY, That I attended deceased from Dec 8 1938, to Dec 8 1938
I last saw him alive on Dec 8 1938. Death is said to have occurred on the date stated above, at 2 P. m.
The principal cause of death and related causes of importance were as follows:
Cerebral apoplexy Date of onset
Other contributory causes of importance: J. W.
Name of operation..... Date of.....
What test confirmed diagnosis?..... 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 W. P. Goyton, M. D.
(Signed) E. D. ... (Address) Edwards Spring 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.

1 X12004

RECEIVED

District Health Officer No. 74
District File Number 2-39-49
Date Filed 1-10-39

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.)