

REC'D FEB 21 1939

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

1477
Do not use this space.

1. PLACE OF DEATH *v*
(a) County *Audrain* Registration District No. *24*
(b) Township *Prairie* Primary Registration District No. *4018* Registered No. _____
(c) City *Ladonia* (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.

2. PRINT FULL NAME *Jessie Mitchell Smith*
(a) Residence, No. *Ladonia Mo* 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 *female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *John A. Smith*
7. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov 2-1857*
8. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *81 2 22*
9. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *House wife*
10. Industry or business in which work was done, as saw mill, bank, etc. _____
11. Date deceased last worked at this occupation (month and year) *1938* 11. Total time (years) spent in this occupation *life*
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Berry, Ill*
13. NAME *Schuyler Gray*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *N.Y.*
15. MAIDEN NAME *Amanda Streeter*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *N.Y.*
17. INFORMANT (ADDRESS) *Allen G. Smith, Mexico, Mo.*
18. BURIAL, CREMATION, OR REMOVAL PLACE *Vandalia Mo* DATE *Jan 25 1939*
19. FUNERAL DIRECTOR (NAME) (ADDRESS) *H. Waininger, Ladonia, Mo.*
20. FILED *1-25*, 1939 *Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Jan, 24*, 1939
22. I HEREBY CERTIFY, That I attended deceased from *Dec 4*, 1938 to *Jan, 24*, 1939
I last saw her alive on *Jan, 23*, 1939 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:
Myocarditis Date of onset *Dec-1938*
9321
Other contributory causes of importance:
Cystitis
Name of operation _____ Date of _____
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) *W. K. McLeall*, M. D.
(Address) *Ladonia Mo*

RECEIVED

District Health Officer No. 10

District File Number 10-34-33

Date Filed FEB 7 1934

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,

H. G. Granger

....., or by

Registered Apprentice No....., working under my personal supervision

Signed.....

H. G. Granger

Licensed Embalmer No. 1297

P. O. Address Saddonia, Mo.

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.)

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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1477
Do not use this space.

1. PLACE OF DEATH

(a) County Wendrain Registration District No. 24
 (b) Township _____ Primary Registration District No. 4018 Registered No. _____
 (c) City Ladonna (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

(a) Residence, No. Jessie Mitchell Smith Ladonna Mo. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John A Smith
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov-2-1887
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
81 2 22
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
 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) 1-38
 11. Total time (years) spent in this occupation Life

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 24, 1939
 22. I HEREBY CERTIFY that I attended deceased from Dec 4, 1938 to Jan 24, 1939
 I last saw her alive on Jan 23, 1939 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:

m. f. Carditis
Cystitis
 Date of onset _____
 Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Berry
 13. NAME Schuyler Gray
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wendrain
 15. MAIDEN NAME Amanda Streets
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wendrain
 17. INFORMANT (ADDRESS) Allen J. Smith
Wendrain Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Wendrain DATE Jan 25, 1939
 19. FUNERAL DIRECTOR (ADDRESS) H. B. Grainger
Ladonna Mo.
 20. FILED 14 5-19-39 W. S. McCall
 Local Registrar.

Name of operation _____ Date of _____
 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? _____
 If so, specify _____
 (Signed) W. S. McCall, M. D.
 (Address) Ladonna Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
 CAUSE OF DEATH TO BE IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.
 AGE SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE SUFFIXED EARLY IN LIFE. PHYSICIAN'S SIGNATURE SHOULD BE SUFFIXED IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

