REC'D FEB 24 1939

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

2893
Do not use this space.

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.

56 30

1. PLACE OF DEATH
(a) County: Lewis
(b) Township: LaBelle
(c) City: LaBelle
Registration District No. 479
Primary Registration District No. 4288
Registered No.
(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 5 yrs. 35 mos. ds. (f) How long in U. S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME: Child of Alba Fountain (Still Born)
(a) Residence, No. 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): —

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Jan 10 1939

7. AGE: Years —; Months —; Days —; If LESS than 1 day, ...hrs. or ....min.

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): LaBelle Mo.

FATHER
13. NAME: Alba H. Fountain
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Lewis Co Mo.

MOTHER
15. MAIDEN NAME: Kathlin Vanskike
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): LaBelle Mo.

17. INFORMANT (ADDRESS): Mr. Alba H. Fountain Williamstown Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE: LaBelle Cemetery DATE: Jan 11, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): James T. Cobb & Son LaBelle Mo.

20. FILED: 1/10, 1939 J. L. Bowers Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Jan 10, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1939, to Jan 10, 1939
I last saw h[illegible] alive Jan 10, 1939. 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
Stillborn	

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) Dr. C. E. Todd, M. D.
(Address) Williamstown Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-39-76
Date Filed FEB 9 1939

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 James T. Coder & Son's, or by

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

Signed William Coder

Licensed Embalmer No. 4723

P. O. Address LaBelle Mo.

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

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