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.

FEB 24 1939

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

2986
Do not use this space.

1. PLACE OF DEATH
(a) County MACON
(b) Township
(c) City MACON
Registration District No. 533
Primary Registration District No. 3027 Registered No. 3
(d) Street No. Samaritan Hospital 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 260 LOTTIE KISOR.
(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: FEMALE
4. COLOR OR RACE: WHITE
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): MARRIED
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ROBERT KISOR
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): July 8 1889
7. AGE: YEARS 49 MONTHS 6 DAYS 1 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. HOUSE WIFE
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): MACON Co. MISSOURI
FATHER
13. NAME: W. W. GARVEN
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): ~~Unknown~~ Missouri
MOTHER
15. MAIDEN NAME: MINNIE McDANIEL
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): ~~Unknown~~ Missouri
17. INFORMANT (ADDRESS): ROBERT KISOR, MACON, MO - Route
18. BURIAL, CREMATION, OR REMOVAL
PLACE Bloomington Cem. DATE Jan. 11, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): H. G. Edwards Bevier
20. FILED 1/9, 1939 Leota Newton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JAN- 9, 1939

I HEREBY CERTIFY, That I attended deceased from April 18, 1931, to Jan. 9, 1939
I last saw her alive on Jan. 9, 1939 Death is said to have occurred on the date stated above, at 3:05A m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchial asthma	1930
105 B	
Other contributory causes of importance: Chronic Bronchiectasis	2 yrs

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) T. P. Gronowski, M.D.
(Address) Macon Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-39-118
Date Filed FEB 8 1933

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 by .....

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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