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.

REC'D FEB 15 1939

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

3336
Do not use this space.

1. PLACE OF DEATH
(a) County Nodaway Registration District No. 617
(b) Township White Cloud Primary Registration District No. 5818 Registered No. 1
(c) City (Bolckow 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 Elmira A Lemaster
(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 Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF William Lemaster
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 15th 1847
7. AGE 91 YEARS 91 MONTHS 6 DAYS 26 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House wife
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) Howard County Indiana

FATHER
13. NAME Horace Lemaster
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York City New York

MOTHER
15. MAIDEN NAME Louisa F Maberry
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT (ADDRESS) Evingston Lemaster
18. BURIAL, CREMATION, OR REMOVAL
PLACE Centinary Cemetery DATE Jan 14 1938
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Campbell Funeral Home 951 South Main Maryville Mo
20. FILED 2/13 1939 Chas D Hubbard Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 11 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan - 9, 1939, to Jan - 11, 1939
I last saw her alive on Jan - 11 - 1939 Death is said to have occurred on the date stated above, at 11 P m.
The principal cause of death and related causes of importance were as follows:

Acute Bronchitis
Senility

Date of onset

Other contributory causes of importance: 106a

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 .....
(Signed) W. Logan Wood, M. D.
(Address) Bolckow Mo.

(Licensed Embalmer's Statement on Reverse Side)

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, W Dean Campbell, or by

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

Signed W Dean Campbell

Licensed Embalmer No. 2620

P. O. Address Maryville 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.