

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

9527
Do not use this space.

1133

Registered No.

1. PLACE OF DEATH

(a) County Jackson 2 Registration District No. 399
 (b) Township Maw 1 Primary Registration District No. 1002
 (c) City Manassas City (d) Street No. 3234 Mc Gee 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 3234 Mc Gee 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 H. J. Pinnell
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec-12-1846
 7. AGE YEARS 92 MONTHS 7 DAYS 0 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
 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) Holt Co. Missouri

FATHER 13. NAME Unknown

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (NAME) Mrs. E. M. Smith
 (ADDRESS) 3234 Mc Gee

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Washington DATE Mar 15 1939

19. FUNERAL DIRECTOR (NAME) Mrs. C. P. Foster
 (ADDRESS) 918 Brooklyn Rd. Mo

20. FILED Mar 12 1939 A. Crowe
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar-12-1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 24th, 1939 to Mar 12th, 1939
 I last saw her alive on Mar 12, 1939 Death is said to have occurred on the date stated above, at 3:10 P.
 The principal cause of death and related causes of importance were as follows:

Myocarditis
Old Age
 Other contributory causes of importance: None

Name of operation None 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? No
 If so, specify
 (Signed) Dr. A. M. Adkins M. D.
 (Address) 423 Lee Bldg

Date of onset

Revere Hotel

Ha 2224-

Nov 1 12 11:00

Free by

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 comply with the above constitutes grounds for revocation of license.)

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