

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

*J. H. Coon*  
540  
10828  
Do not use this space.

1. PLACE OF DEATH ~~GREENE~~ GREENE Registration District No. 316  
 (a) County.....  
 (b) Township..... Primary Registration District No. 2001  
 (c) City SPRINGFIELD (d) Street No. 1430 Washington Registered No. 242  
 (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 *Fannie Keel Smith*  
 (a) Residence, No. 1430 Washington St. \_\_\_\_\_ (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*) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF *Dr. J. R. Smith (1917)*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept. 21, 1844*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*1 94 5 29*

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Un Home*

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) *Washington, Missouri*

13. NAME *J. E. Keel*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *England*

15. MAIDEN NAME *Elizabeth P. West*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Alabama*

17. INFORMANT (ADDRESS) *Mrs. Grace Cooper, Springfield, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Hazelwood* DATE *May 22, 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Alma Schaefer, Springfield, Mo.*

20. FILED *Mar 21, 1939 Ches. W. George, Mo. Local Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 20, 1939*

22. I HEREBY CERTIFY, That I attended deceased from *Nov. 5, 1938, to March 20, 1939*  
 I last saw her alive on *March 19, 1939* Death is said to have occurred on the date stated above, at *10:45 A.M.*  
 The principal cause of death and related causes of importance were as follows:  
*Patient had a frost of right hip 12 or 13 yrs. ago. Hip by a fall continued same kind of disease which she gradually failed in vitality.*  
 Date of onset *11-5-38*

Other contributory causes of importance:  
*Senility was major cause of death.*

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? *accident* Date of injury *Nov 5, 1938*  
 Where did injury occur? *at home*  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. *In home*

Manner of injury *only contusion of hip*  
 Nature of injury *by a fall on floor*

24. Was disease or injury in any way related to occupation of deceased? *No.*  
 If so, specify \_\_\_\_\_

(Signed) *J. H. Coon*, M. D.  
 (Address) *Springfield, Mo.*

WRITE PLAINLY WITH OR WITHOUT INK  
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.

**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.**