

1939 APR 11 1939

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

10924
Do not use this space.

1. PLACE OF DEATH
 (a) County Harrison 2 Registration District No. 341
 (b) Township Ridgeway 1 Primary Registration District No. 4204
 (c) City Ridgeway (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 530 MELISSA E. Smith
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF William H. Smith

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 13, 1846

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>92</u>	<u>6</u>	<u>14</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

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) unk

11. Total time (years) spent in this occupation 70

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 27 39

22. I HEREBY CERTIFY, That I attended deceased from Jan 1 1938, to Feb 27 1939
 I last saw her alive on Feb 27 1939. Death is said to have occurred on the date stated above, at 3:00 p.m.
 The principal cause of death and related causes of importance were as follows:
Myocarditis
 Date of onset 1932

Other contributory causes of importance:
Senility

Name of operation None Date of _____
 What test confirmed diagnosis? Physical 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) R. L. LeBrewner, M. D.
 (Address) Ridgeway Mo
309 Local Registrar.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk Illinois

FATHER

13. NAME Isaac Downay

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk unk

MOTHER

15. MAIDEN NAME unk

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk unk

17. INFORMANT (ADDRESS) William Smith Ridgeway Mo

18. BURIAL, CREMATION OR REINTERMENT PLACE Gamble Ridge DATE 2/3 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rodan Son Ridgeway Mo

20. FILED Mar 3 39 LeBrewner Local Registrar.

(Licensed Embalmer's Statement on Reverse Side)

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.

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

4180

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RECEIVED

District Health Officer No. 11,

District File Number 39-244

Date Filed APR 7 1928

ASSEMBLED BY A. H. ...

10 311

920

APR 11 1928

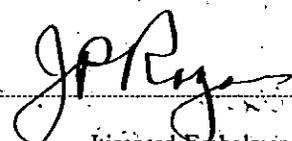
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STATEMENT BY LICENSED EMBALMER

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. 2020

P. O. Address Ridgeway

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.