

REC'D MAY 19 1939

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

16295

Do not use this space.

1. PLACE OF DEATH ²
- (a) County Shelby Registration District No. 830
 (b) Township East River Primary Registration District No. 4503
 or
 (c) City Shelbina (d) Street No. _____ 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 ⁶⁵³ Mattie Bell Francis
- (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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Divorced</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) _____ OF <u>David Hudson Francis</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>June 14, 1899</u>		
7. AGE	YEARS <u>79</u>	MONTHS <u>9</u>
		DAYS <u>11</u>
		If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>	
	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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 25, 1939

22. I HEREBY CERTIFY, That I attended deceased from 1929, 19____, to Mar., 1939

I last saw her alive on March 21, 1939. Death is said to have occurred on the date stated above, at 4 A. m.

The principal cause of death and related causes of importance were as follows:

Arterio-sclerosis

Date of onset

10 yrs

Other contributory causes of importance:

Name of operation None 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? No
 If so, specify _____
 (Signed) J. P. Harrison, M. D.

(Address) Shelbina, Mo.

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Marion County, Missouri</u>
	13. NAME <u>William E. Wilson</u>
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't know</u>
	15. MAIDEN NAME <u>Mary Elizabeth Jackson</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Madison County, Missouri</u>
	17. INFORMANT <u>A. Sparks</u> (ADDRESS) <u>Kansas City, Mo.</u>
	18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Shelbina, Mo.</u> DATE <u>Mar 26, 1939</u>
	19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>E. Hayes</u> <u>Shelbina, Missouri</u>
	20. FILED <u>May 8, 1939</u> <u>Ruth Jayner</u> 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.

RECEIVED

District Health Officer No. 10

District File Number 10-29-947

Date Filed MAY 11 1939

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.....

Myself
working under my personal supervision.

....., Registered Apprentice No.....

Signed E. Hayes

Licensed Embalmer No. 1437

P. O. Address Shepherd, Mo

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.