

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**

16793
Do not use this space.

REC'D JUN 12 1939

2

1. PLACE OF DEATH

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No. **4327**
 (c) City St. Louis..... (d) Street No. 2585^a Montgomery 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

5-11-39 Matthe Smith
 (a) Residence, No. 2589^a Montgomery St. **20** (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 Cal 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm Smith
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1 1891
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
58 4 7
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Domestic
 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) Macon Mo

FATHER 13. NAME Jim Hiser

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Huntsville Mo

MOTHER 15. MAIDEN NAME Annie Kirkley

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Huntsville Mo

17. INFORMANT (ADDRESS) Robt Smith 2589^a Montgomery

18. BURIAL, CREMATION, OR REMOVAL PLACE WASHINGTON PK DATE 5-11-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. F. Buddie WALTER 2707 Stoddard St

20. FILED MAY 9 1939 J. F. Buddie Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-7 1939

22. I HEREBY CERTIFY, That I attended deceased from 5-1 1939, to 5-7 1939
 I last saw her alive on 5-7 1939 Death is said to have occurred on the date stated above, at 7A m.
 The principal cause of death and related causes of importance were as follows:

Rheumatic Heart Disease @ Decomposition
 Date of onset About 6 mos ago

Other contributory causes of importance: PH

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?..... 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) A. M. Williams M. D.
 (Address) 823-116th St

78
E
50

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,

William C. McDowell

or by

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

Signed

William C. McDowell

Licensed Embalmer No.

2114

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.