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.

JUN 19 1939

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

19148
Do not use this space.

1. PLACE OF DEATH
(a) County Macon
(b) Township
(c) City Macon
(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.

Registration District No. 533
Primary Registration District No. 3027
Registered No. 53

2. PRINT FULL NAME Cora Smith
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city)
(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF P. R. Smith
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 3rd 1864
7. AGE YEARS 74 MONTHS 8 DAYS 22 If LESS than 1 day, ... hrs. or ..... min.

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. House wife
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) Van Buren Co Iowa

FATHER
13. NAME Isaac Streight
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

MOTHER
15. MAIDEN NAME Phoebe Streight
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

17. INFORMANT (ADDRESS) Mr P. R. Smith Macon, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Wood DATE 5-27-39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stephens & Godding Macon, Mo.
20. FILED 6/3, 1939 Leota Newton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 25, 1939
22. I HEREBY CERTIFY, That I attended deceased from Dec. 1937, to May 25, 1939
I last saw her alive on May 24, 1939. Death is said to have occurred on the date stated above, at 6.45 a.m.
The principal cause of death and related causes of importance were as follows:
Thrombosis of l. iliac artery c̄ gangre of l. leg. 5/22/39.
Date of onset
Other contributory causes of importance:
General Artero-sclerosis 1930F
Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical 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) T. F. Turner, M. D.
(Address) Macon, Mo.

(Licensed Embalmer's Statement on Reverse Side)

1938
1864
74-8-22

Sept 3rd

RECEIVED
District Health Officer No. 10
District File Number 10-39-1057
Date Filed JUN 7 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, C. L. Stephens, or by .....

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

Signed C. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

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