

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.

REC'D JUN 13 1939

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

19386
 Do not use this space.

1. PLACE OF DEATH

(a) County Osgage Registration District No. 1124 5056
 (b) Township Jefferson Primary Registration District No. 58519 Registered No. 15
 (c) City _____ (d) Street No. _____ St. 4
 (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 THOMAS SMITH

(a) Residence, No. GASCONDY MO. 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>MALE</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) WIFE OF <u>UNKNOWN</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>1879</u>		
7. AGE YEARS <u>about 60</u>	MONTHS	DAYS
If LESS than 1 day, _____ hrs. or _____ min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>MANAGER</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>GASCONDY RESORT</u>	
	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) <u>ST. LOUIS MO</u>	0	
FATHER	13. NAME <u>UNKNOWN</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>"</u>	
MOTHER	15. MAIDEN NAME <u>"</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>"</u>	
17. INFORMANT <u>Chas Stehlmacher</u> (ADDRESS) <u>Gascondy MO</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>CALVARY CEM.</u> DATE <u>MAY 13 1939</u>		
19. FUNERAL DIRECTOR (NAME) <u>ARTHUR J DONNELLY</u> (ADDRESS) <u>3840 LINDELL BLVD ST LOUIS MO</u>		
20. FILED <u>6-8-</u> 19 <u>39</u> <u>Wm Dill Beechler</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) MAY 10 1939

22. I HEREBY CERTIFY That I attended deceased from Feb 27th 1939 to May 10th 1939
 I last saw him alive on April 19 1939 Death is said to have occurred on the date stated above, at 9:20 P.M.
 The principal cause of death and related causes of importance were as follows:

Date of onset	
<u>Myocarditis (Chronic)</u>	<u>2/12 1939</u>
Other contributory causes of importance:	
<u>Hypertension (Chronic)</u>	<u>131</u>

Name of operation _____ Date of _____
 What test confirmed diagnosis? clin + lab 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) A. H. Barstow
 (Address) Franklin, Mo

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 Stanley Marshall

Licensed Embalmer No. 2868

P. O. Address 3840 Lyndell

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.