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.

27 JUL 8 1939

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

22571
Do not use this space.

58
1
2

1. PLACE OF DEATH

(a) County Linn — Registration District No. 496

(b) Township — Primary Registration District No. 3075 — Registered No. 60

(c) or City Brookfield — (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 50 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 530 Alvernia E. Smith

(a) Residence, No. 427 Pleasant 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: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Franklin P. Smith

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): March 24, 1850

7. AGE: YEARS 89 — MONTHS 2 — DAYS 24 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
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): 1935
11. Total time (years) spent in this occupation: 65

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Steubenville Ohio

FATHER
13. NAME: James Atkinson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): West Virginia

MOTHER
15. MAIDEN NAME: Mary Ann Davis
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Pennsylvania

17. INFORMANT (ADDRESS): Mrs. Carrie Hargadine, Brookfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL: Rose Hill Cem. Brookfield, Mo. — PLACE — DATE June 20, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Rusk Funeral Home, Brookfield, Mo.

20. FILED July -1- 1939 Jno H Lucas, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): June 18, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1939, to June 15, 1939. I last saw her alive on June 15, 1939. Death is said to have occurred on the date stated above, at 9:30 a m.

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

	Date of onset
Cerebral Embolism	5/29/39
82 b	

Other contributory causes of importance:

General Arteriosclerosis	?
Chronic Endometritis	?

Name of operation: none — Date of: —

What test confirmed diagnosis? 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) Roy R Halsey, M. D.
(Address) Brookfield Mo

445

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number 739-764
Date Filed JUL 6 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 ....., Registered Apprentice No. ..... working under my personal supervision.

Signed H. B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, I

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

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