N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo

REC'D JUL 13 1939

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

23425
Do not use this space.

1. PLACE OF DEATH
(a) County Stoddard Registration District No. 834
(b) Township Pike Primary Registration District No. 4506 Registered No.
(c) City Bell City (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.

2. PRINT FULL NAME 430 Lizzie (Lizzie) Holt
(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 fem
4. COLOR OR RACE w
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6/23/39
7. AGE YEARS 60 MONTHS — DAYS 5 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House keeping
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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson Mo

FATHER
13. NAME James Cotner
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

MOTHER
15. MAIDEN NAME Don't Know
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't Know

17. INFORMANT (ADDRESS) Chester Holt Bell City Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Carpenter Cemetery DATE 6/28 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. Welch Sikeston Mo
20. FILED ....., 19.... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/28, 1939
22. I HEREBY CERTIFY, That I attended deceased from 6/18, 1939, to 6/28, 1939
I last saw her alive on 6/27, 1939. Death is said to have occurred on the date stated above, at 3 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	6/27/39
Other contributory causes of importance: Chronic Nephritis (Hypertension)	Possibly 1938

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... 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) J. A. Cline, M. D.
758 (Address) Oran Mo

Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 2
District File Number 239-66
Date Filed 2-12

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.

Body not embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

23425
Do not use this space.

1. PLACE OF DEATH
(a) County Stoddard — Registration District No. 834
(b) Township — Primary Registration District No. 45-06 — Registered No. 30
(c) City Bell City (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.

2. PRINT FULL NAME Lizzie Lizzie Holt
(a) Residence, No. 00 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 F — 4. COLOR OR RACE W — 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6/23/1879

7. AGE — Years 60 — Months — — Days 5 — If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeping
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

12. BIRTHPLACE (CITY OR TOWN) Jackson (STATE OR COUNTRY) Mo

FATHER
13. NAME James Cotner
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Known

17. INFORMANT Chester Holt (ADDRESS) Bell City Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Carpenter Cem DATE 6/28 1939

19. FUNERAL DIRECTOR H. E. Welch (ADDRESS) Sikeston Mo

20. FILED Aug 14 1939 D. S. McGee Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6/28 1939

22. I HEREBY CERTIFY, That I attended deceased from 6/18 1939 to 6-28 1939
I last saw he alive on 6-27 1939. Death is said to have occurred on the date stated above, at 3 A. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	6/27/39

Other contributory causes of importance: Chronic nephritis

Name of operation ____ Date of ____
What test confirmed diagnosis? ____ 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? ____
If so, specify ____
(Signed) J. A. Cline, M. D.
(Address) Oran Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.