

REC'D AUG 17 1939

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

25535

Do not use this space.

1. PLACE OF DEATH

(a) County Dunklin Registration District No. 289
 (b) Township Cotton Hill Primary Registration District No. 5407 Registered No. 21
 (c) City or _____ (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

(a) Residence, No. _____ 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>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Still born</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF <u>Still born</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		<u>Still born</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc.		<u>Still born</u>	
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation <u>✓</u>	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 26th, 1939
 22. I HEREBY CERTIFY That I attended deceased from 7/29/1939 to 7/29/1939
 I last saw her still born 7/26/1939 Death is said to have occurred on the date stated above, at 8:15 p.m.
 The principal cause of death and related causes of importance were as follows:

Small Pox in mother 7/5/39

Date of onset

7/5/39

Other contributory causes of importance:

Name of operation None Date of ✓
 What test confirmed diagnosis? History 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 ✓, 1939
 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) S.E. Mitchell, M. D.(Address) Malden Mo12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) R#1 Radeon Mo13. NAME Glenn Kelly14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pineacott Co. Mo15. MAIDEN NAME Dorothy Greenes16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Warehouse Mo17. INFORMANT (ADDRESS) Glenn Kelly R#1 Radeon Mo18. BURIAL, CREMATION, OR REMOVAL PLACE On farm DATE 7/27/193919. FUNERAL DIRECTOR (NAME) (ADDRESS) None20. FILED 8/27/1939 S.E. Mitchell Local Registrar

(Licensed Embalmer's Statement on Reverse Side)

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.

I X 16603

RECEIVED

District Health Officer No. 3,

District File Number 839-512

Date Filed 8/11/39

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.....

Licensed Embalmer No.....

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.