

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

26348  
Do not use this space.

**1. PLACE OF DEATH**

(a) County New Madrid Registration District No. 607  
 (b) Township Portage Primary Registration District No. 5806  
 (c) City Portagaville (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 Hawk  
 (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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dont Know  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
About 38

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.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation  
Dont Know

12. BIRTHPLACE (CITY OR TOWN) Hickman, (STATE OR COUNTRY) Ky.

13. NAME Black Hawk

14. BIRTHPLACE (CITY OR TOWN) Covington, Ky. (STATE OR COUNTRY)

15. MAIDEN NAME Ada Clark

15. BIRTHPLACE (CITY OR TOWN) Tenn. (STATE OR COUNTRY)

17. INFORMANT Black Hawk. (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Portagaville DATE 7-19-39

19. FUNERAL DIRECTOR (NAME) H. M. Payne (ADDRESS) Portagaville, Mo.

20. FILED 7-31, 19 39 Mary W. Carter Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

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

22. I HEREBY CERTIFY, That I attended deceased from July 14th 39 only, to \_\_\_\_\_, 19\_\_\_\_.

I last saw her alive on July 14th 39, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 9 A.M.

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

Acute Remittent Malaria July 8, 39

Other contributory causes of importance:

Chronic Endocarditis due to Rheumatism & enveterate smoking.

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) H. M. Payne M. D.

(Address) Portagaville, Mo.

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

RECEIVED

District Health Officer No. 1

District File Number 839-118

Date Filed 8-4

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.