

NOV 24 1939

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

36590  
Do not use this space.

1. PLACE OF DEATH

(a) County McDonald 2 Registration District No. 142  
(b) Township Buffalo 1 Primary Registration District No. 5696 Registered No. ....  
(c) City ..... (d) Street No. .... St. ....  
(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)  
Jola Sirina Michael

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female  
4. COLOR OR RACE white  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF P. J. Michael  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 16 - 1868  
7. AGE YEARS 71 MONTHS 6 DAYS 1 If LESS than 1 day, ..... hrs. or ..... min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper  
9. Industry or business in which work was done, as law mill, bank, etc. Housekeeper  
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) Kans

FATHER 13. NAME John Edwards

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Yorktown

MOTHER 15. MAIDEN NAME Elizabeth Phillips

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) P. J. Michael  
Goodman mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Howard Cemetery DATE Oct 19 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Chas. W. Williams  
Goodman mo

20. FILED 11-10, 1939 Chas. W. Williams  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 17 1939

22. I HEREBY CERTIFY, That I attended deceased from 5-1, 1939, to Oct 17, 1939  
I last saw h. or alive on Oct 17, 1939. Death is said to have occurred on the date stated above, at ..... m.

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

Hypertensive cardiac  
decompensation and  
Cerebral Hemorrhage  
(left side) Date of onset Oct 8-9

Other contributory causes of importance: 21  
arterio-sclerosis,  
chronic interstitial  
nephritis

Name of operation none Date of .....  
What test confirmed diagnosis? clinical 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? .....  
If so, specify no  
(Signed) Malvin C. Bowman, M. D.  
Keosho, Mo (Address)

WHITE 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.

1 X14023

RECEIVED

District Health Officer No. 6,

District File Number 1139-2364

Date Filed NOV 14 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 Marjellen Williams

Registered Apprentice No. 234, working under my personal supervision.

Signed

J. Bohann

Licensed Embalmer No. 2689

P. O. Address Keokuk Mo

**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.**