NOV 2 4 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

37013
Do not use this space.

1. PLACE OF DEATH
(a) County Ray
(b) Township Polk
(c) City Lawson-Mo
Registration District No. 742
Primary Registration District No. 5977a
Registered No.
(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 James ELMore Smith
(a) Residence, No. 530 Ray Co. Lawson Mo. 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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): No.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 24, 1920
7. AGE: Years 18 | Months 10 | Days 7 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
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. None
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) Lawson Mo

FATHER
13. NAME James Sidney Smith C
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lawson Missouri C

MOTHER
15. MAIDEN NAME Fawntine Elmore
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT W.R. Morrow
(ADDRESS) Excelsior Spgs. Mo.
18. BURIAL, ~~CREMATION, OR REMOVAL~~
PLACE Lawson Mo DATE 11-1, 1939
19. FUNERAL DIRECTOR (NAME) Morrow + Moler
(ADDRESS) Lawson Mo.
20. FILED Nov. 1, 1939 Edwin S Rowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 31, 1939
22. I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1939, to Oct. 31, 1939
I last saw him alive on Oct. 31, 1939. Death is said to have occurred on the date stated above, at 1:15 Am.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Left Lobar Pneumonia	Oct 25
Cardiac Asthma	Sept 30
Streptococcic Sore Throat	Oct 15

Other contributory causes of importance: None

Name of operation ..... 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? No
If so, specify .....
(Signed) Betty Buchanan, M. D.
(Address) Lawson Mo.

(Licensed Embalmer's Statement on Reverse Side)

MARGIN RESERVED FOR BINDING
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.

V. S. No. 2.
50M-1-12-38
1 X14028

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11/7/39

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 James A Moles

Licensed Embalmer No. 3296

P. O. Address Excelsior Springs 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.