

DEC 15 1939

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

39500  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Dunklin Registration District No. 289  
 (b) Township Malden Primary Registration District No. 5407-17 Registered No. 38  
 (c) City Malden 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 SLVA Imogene Phelps  
 (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 3/39  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. or ... min. 0 0 0  
 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 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 3 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Nov 3 1939 to Nov 3 1939  
 I last saw her alive on Still born Death is said to have occurred on the date stated above, at 11 P.M.  
 The principal cause of death and related causes of importance were as follows:  
undeveloped heart  
pericardial area failed  
to close  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_  
 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? no Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? None (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury None  
 Nature of injury None  
 24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_ (Signed) W. G. Reed M. D.  
John W. Reed (Address) \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dunklin Co Mo  
 13. NAME Reed Philip  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
 15. MAIDEN NAME Ethel Sullivan  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
 17. INFORMANT (ADDRESS) W. G. Reed  
 18. BURIAL, CREMATION, OR REMOVAL PLACE North White Oak Nov 5 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) None  
 20. FILED 11-4 1939 St. Mitchell Local Registrar.

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.

RECEIVED

District Health Officer No. 3,

District File Number 1239-704

Date Filed 12/8/39

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**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.**