

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.

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Caroney & Son Co.

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

DEC 15 1939

**39605**  
 Do not use this space.

1. PLACE OF DEATH  
 (a) County GREENE Registration District No. 318  
 (b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 824  
 (c) City SPRINGFIELD (d) Street No. 425 E. Madison 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 Arthur Smith  
 (a) Residence, No. 425 E. Madison 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 Male 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 Jessie Smith  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 1, 1883  
 7. AGE YEARS 56 MONTHS 4 DAYS 12 If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Ret. Grocer  
 9. Industry or business in which work was done, as saw mill, bank, etc. Dr. Store  
 10. Date deceased last worked at this occupation (month and year) 1939 11. Total time (years) spent in this occupation 16 1/2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tex  
 FATHER  
 13. NAME John Smith  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Georgia  
 MOTHER  
 15. MAIDEN NAME Senora Roberts  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sick Creek, Ill.

17. INFORMANT (ADDRESS) Jessie Smith, Springfield, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. View, Mo. DATE Nov. 15, 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alma Schreyer, Springfield, Mo.  
 20. FILED Nov 15 1939 Chas. George 1939 1611 1939

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 13, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from I last saw him live on Nov 13, 1939 to ..... 19..... Death is said to have occurred on the date stated above, at 4:30 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Suicide by hanging  
 Date of onset

Other contributory causes of importance: 16 1/2  
 Name of operation None Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? No.

23. If death was due to external cause (violence), fill in also the following:  
 Accident, suicide, or homicide? Suicide Date of injury 11-13-39  
 Where did injury occur? 425 East Madison St. Springfield, Mo.  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. in home  
 Manner of injury Suicide by hanging  
 Nature of injury Strangulation

24. Was disease or injury in any way related to occupation of deceased? No.  
 If so, specify.....  
 (Signed) J. B. Brown, Acting Coroner  
 (Address) 1622 N. 13th St. Springfield, Missouri

**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 conform with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**