

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

39804
Do not use this space.

1. PLACE OF DEATH

(a) County Newell Registration District No. 384
 (b) Township West Plains Primary Registration District No. 4227 Registered No. _____
 (c) City _____ (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred 5 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 420 Frankie Belle Black 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dr. J. H. Black
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-15-1883
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 8 18
 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. Housewife
 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) Newell Co., Mo

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-3-1939
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
 I last saw h_____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 3:30 P.M.
 The principal cause of death and related causes of importance were as follows:

Chronic myocarditis

Date of onset

Other contributory causes of importance: ASC

FATHER
 13. NAME Smith
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unk
 MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) Mrs. Geo. Smith
Osida, Kansas
 18. BURIAL, CREMATION, OR REMOVAL PLACE South Park DATE 11-6-1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robinson
West Plains Mo
 20. FILED 11-6-1939 Vida W. Simons
 Local Registrar

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? _____
 If so, specify _____
 (Signed) Mayme C. Thornburgh _____
 (Address) West Plains, Mo.

Coroner

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.

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.

District Health Officer No. 5,

District File Number. 1239436

Date Filed 12839

Signed D. D. Roberts

Licensed Embalmer No. 3432

P. O. Address West Paris 7

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.