

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.

Registration District No. 474

Primary Registration District No. 5628

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town Ash Grove, R 7 S #3
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

8. (a) PRINT FULL NAME Margaret J. Smalling ⁵⁴⁵
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____
4. Sex Female 5. Color or race white
6. (b) Name of husband or wife Robert Smalling 6. (a) Single, widowed, married, divorced widow
7. Birth date of deceased Nov. 13 1853
(Month) (Day) (Year)

8. AGE: Years 85 Months 11 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Arkansas (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____
MOTHER FATHER { 12. Name Maek Siciliano !
13. Birthplace Ark
14. Maiden name Isabell Duke
15. Birthplace Ark

16. (a) Informant's own signature R. S. Hall
(b) Address Ash Grove

17. (a) Burial (b) Date of death Nov-12-1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Rock Springs, near Herculano

18. (a) Signature of funeral director Ernie Funeral Service
(b) Address Ash Grove

19. (a) Nov-13, 1939 (b) Mrs. Anna Wilkerson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lawrence
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Ash Grove (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 12
year 1939 hour 9:01 minute _____ P. M.
21. I hereby certify that I attended the deceased from Nov
_____, 1939, to Nov-12-, 1939;
that I last saw her alive on Nov 12 -, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Oedema
Due to an ulcerated throat
Due to _____
Other conditions (Include pregnancy within 3 months of death) 1150
Major findings: Of operations no
Of autopsy none

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Charles H. McPherson (M. D. certifier)
Address Ash Grove Date signed 11-13-39

RECEIVED

District Health Officer No. 6,

District File Number 1239-2524

Date Filed DEC 7 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.....

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

Signed Lucas Brown

Licensed Embalmer No. 2664

P. O. Address W. H. Brown

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.