

JAN 11 1939

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

42935  
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway 2 Registration District No. 104  
(b) Township Fulton 1 Primary Registration District No. 3008  
(c) City \_\_\_\_\_ (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

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
Mrs Maggie Chambers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank  
7. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 24-1880  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
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) Dec 13 1939  
22. I HEREBY CERTIFY, That I attended deceased from July 29 1939 to Dec 13 1939  
I last saw h.s. alive on Dec 13 1939 Death is said to have occurred on the date stated above, at 11:45 p.m. m.  
The principal cause of death and related causes of importance were as follows:

Myocarditis (Chronic) 93C

Other contributory causes of importance:  
Fibroid tumor of the uterus

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) D. G. Richardson M. D.  
(Address) Fulton Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
13. NAME Solomon Kemp  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.C. 9  
15. MAIDEN NAME Winnie Brown  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.C.  
17. INFORMANT (ADDRESS) Mrs Jewel Johnson  
Fulton, Mo  
18. BURIAL, CREMATION OR REMOVAL PLACE Fulton, Mo DATE Dec 16 1939  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Eli Bell  
Fulton, Mo  
20. FILED Dec 15 1939 R. N. Crews  
Local Registrar.

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.

Signed.....

*Eli Bell*

Licensed Embalmer No.....

*2130*

P. O. Address.....

*Fulton, 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.**