

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.

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

Do not use this space.

16314

1. PLACE OF DEATH

County Stone Registration District No. 843
Township Lagan Primary Registration District No. 6085
City Galena (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____, St. _____, Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>wh</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>✓</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 13 - 1940</u>				
7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.	
	<u>1</u>	<u>15</u>		
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
FATHER	12. BIRTHPLACE (CITY OR TOWN) <u>Galena, mo.</u> 0 (STATE OR COUNTRY) <u>Stone, Co.</u>			
	13. NAME <u>Charley Smith</u> 0			
	14. BIRTHPLACE (CITY OR TOWN) <u>Stone Co.</u> 0 (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME <u>Amby Austin</u>			
	16. BIRTHPLACE (CITY OR TOWN) <u>Stone, Co.</u> (STATE OR COUNTRY)			
17. INFORMANT <u>Charley Smith</u> (ADDRESS) <u>Galena, mo.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Galena Cemetery</u> DATE <u>March 28 1940</u>				
19. UNDERTAKER <u>No Undertaker</u> (ADDRESS)				
20. FILED <u>4/25</u> , 19 <u>40</u> <u>Nellie Ironby</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 27 1940

22. I HEREBY CERTIFY, That I attended deceased from sawyer at birth to _____, 19____
I last saw her alive on Feb 13 - _____, 1940 Death is said to have occurred on the date stated above, at 2 P m.
The principal cause of death and related causes of importance were as follows:
Premature birth
Date of onset _____

Other contributory causes of importance: CH
IC

Name of operation _____ Date of _____
What test confirmed diagnosis? Clived Was there an autopsy? no

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) H. L. Trew, M. D.
(Address) Crane Mo.

RECEIVED

District Health Officer No. 5,

District File Number 540-1220

Date Filed MAY 6 1940