

Exact statement of OCCUPATION is very important.

OCT 13 1938

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

Do not use this space.

27491

1. PLACE OF DEATH
 County Linn Registration District No. 1102
 Township Parola Primary Registration District No. _____
 City Parola (No. _____) St. _____ Ward _____

2. FULL NAME Lillian Smith (nee) Fletcher
 (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. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
 4. COLOR OR RACE col.
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married
 5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF (OR) WIFE OF Robert Smith
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 / 9 / _____
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work House Keeping
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Edds
 (STATE OR COUNTRY) Tenn

PARENTS

10. NAME OF FATHER Geo Fletcher
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Monte Janice
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tenn
 (STATE OR COUNTRY) _____

14. INFORMANT Geo Fletcher
 (Address) Parola Mo

15. FILED _____, 19____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 38
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Purpural Septicemia
(Case history)
145 hr. (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 140 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) James P. Wehring M. D.
 (Address) Brookwood, Mo

*State the DISEASE CAUSING DEATH, only deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. Carotid

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Morgan Cemetery DATE OF BURIAL Aug 11 1938
 20. UNDERTAKER Ruth Davis ADDRESS Parola Mo

MAR 3 1949

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

OCT 31 1930

1. PLACE OF DEATH
 County Peru Registration District No. 1102 File No. _____
 Township Parola Primary Registration District No. 5870 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Lillian Smith (nee) Fletcher
 (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. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OR (OR) WIFE OF Rosvelt Smith

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
18 9

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work House keeping
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Edde
 (STATE OR COUNTRY) Tenn

10. NAME OF FATHER Geo. Fletcher

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Edde
 (STATE OR COUNTRY) Tenn

12. MAIDEN NAME OF MOTHER Maie Yarnie

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Edde
 (STATE OR COUNTRY) Tenn

14. INFORMANT Geo. Fletcher
 (Address) Parola, Mo.

15. FILED 10-8-30 Mrs. P. R. Cole
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 11 19 30

17. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, _____, _____, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemia
base history

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH, _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? General
 (Signed) James J. Vickrey, M. D.
Aggadonia

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Coroner

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Morgan Cemetery DATE OF BURIAL Aug 11 1930

20. UNDERTAKER Hugh Davis ADDRESS Hayti Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S. 27491