

REC'D AUG 8 1938

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

24481

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Ray mo. Primary Registration District No. 100 Registered No. 2986  
 (c) City Ray mo. (d) Street No. General Hosp. #23 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. 2300 Woodland 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 Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-15-38

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
 \_\_\_\_\_

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
 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 \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ray mo.

FATHER 13. NAME Fred Waters  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.

MOTHER 15. MAIDEN NAME Lillie Michael  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark.

17. INFORMANT (ADDRESS) Record Clerk General Hospital18. BURIAL, CREMATION, OR REMOVAL PLACE Deeds Cem. DATE 7-25-3819. FUNERAL DIRECTOR (ADDRESS) W. H. Spitzer & Son20. FILED July 25, 1938 M. E. Brown Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-16 1938

22. I HEREBY CERTIFY, That I attended deceased from 7-15 1938 to 7-16 1938  
 I last saw her alive on 7-16 1938 Death is said to have occurred on the date stated above, at 5:45 P.M.  
 The principal cause of death and related causes of importance were as follows:

Strangulated Umbilical Hernia (Operated)  
 Date of onset 15th

Other contributory causes of importance:

Name of operation Hernioplasty Date of 7/16/38  
 What test confirmed diagnosis? \_\_\_\_\_ 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? No  
 If so, specify \_\_\_\_\_  
 (Signed) W. H. Spitzer M.D.  
 (Address) General Hosp. #23

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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, *O. W. West*, Licensed Embalmer No. 2710

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. ....

No. .... or by ....., Registered Apprentice No. ....

working under my personal supervision.

Signed *O. W. West*

Licensed Embalmer No. 2710

**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.)**