

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

34504  
Do not use this space.

RECD NOV 21 1938

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399  
 (b) Township Okma Primary Registration District No. 1002  
 (c) City Lansbury (d) Street No. 2000 Registered No. 3840  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. 1 yr 2 mos 10 ds (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 1308 1/2 St. 1st (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 <u>7</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widow of Denton</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Jan 30 1890</u>		
7. AGE YEARS <u>48</u>	MONTHS <u>7</u>	DAYS <u>29</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>W.P.A.</u>		11. Total time (years) spent in this occupation
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)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>		
13. NAME <u>John Smart</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>ky</u>		
15. MAIDEN NAME <u>Virginia Faine</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo</u>		
17. INFORMANT (ADDRESS) <u>Dr. J. C. De Maria</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Green Lawn</u> DATE <u>Oct 9 1938</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>A. P. Doshler</u> <u>1415 East 15th</u>		
20. FILED <u>Oct 3 1938</u> <u>M. M. Crowe</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-29 1938

22. I HEREBY CERTIFY, That I attended deceased from 9-27, 1938 to 9-29, 1938  
 I last saw him alive on 9-29, 1938 Death is said to have occurred on the date stated above, at 11:30 AM  
 The principal cause of death and related causes of importance were as follows:  
Mesenteric thrombosis  
Sanguineous small intestine  
12:30

Other contributory causes of importance:

Name of operation Autopsy Date of 10/1/38  
 What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

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) P. J. De Maria, M. D.  
 (Address) 2000 Okma

---

---

**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.....

Licensed Embalmer No.....

P. O. Address .....

**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.**