

1939 APR 11 1938

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

12145  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 775  
(b) Township Big Rivers Primary Registration District No. 6019 Registered No. 23  
(c) City Smiths Fork (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(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. 354 Ollie Stanley St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 26 - 1881  
7. AGE YEARS 57 MONTHS 2 DAYS 18 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. house work  
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) Carroll Co. Mo.  
13. NAME Emma Jones  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky  
15. MAIDEN NAME Mary Anderson  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carroll Co. Mo.  
17. INFORMANT (ADDRESS) Chris Stanley  
18. BURIAL, CREMATION, OR REMOVAL PLACE Lucas Springs DATE 3/16/39  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) First Burial Co. Fulton Mo.  
20. FILED Mar. 14, 1939 N. W. Hawkins Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 13 - 1939  
22. I HEREBY CERTIFY, That I attended deceased from Mar. 10, 1939 to Mar. 13, 1939. I last saw her alive on Mar. 13, 1939. Death is said to have occurred on the date stated above, at 6:30 P. M.  
The principal cause of death and related causes of importance were as follows:  
Cancer of internal organs. Date of onset Aug. 1938  
Other contributory causes of importance: \_\_\_\_\_  
Name of operation Exploratory operation Date of Sept. 1938  
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? no.  
If so, specify \_\_\_\_\_  
(Signed) R. B. Lester M. D.  
DeLoze M. D.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impor

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STATEMENT BY LICENSED EMBALMER

**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.**

STATEMENT BY LICENSED EMBALMER

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH  
(a) County St. Francois Registration District No. 775  
(b) Township Big River Primary Registration District No. 6019  
(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 Ollie Stanley  
(a) Residence, No. .... 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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 13, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to ... 19...

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

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
57 2 18

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
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.....

Cancer of Internal Organs # N. M. B. # Date of onset Aug 1934

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

Other contributory causes of importance: 53'

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE, DATE, 19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED, 19.. Local Registrar.

Name of operation Exploratory 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) R. B. Lester, M. D.  
(Address) Dea. Lodge Dea

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY MOORE

SUPPLEMENTARY

