

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

25897  
 Do not use this space.

REC'D AUG 17 1939

**1. PLACE OF DEATH**

(a) County Jasper Registration District No. 411  
 (b) Township Adella Primary Registration District No. 2002 Registered No. ....  
 or  
 (c) City Jasper (d) Street No. Freeman Hospital 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. Galena House Route 1 St.  Galena, Kas.  
 (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 [Redacted] 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widow  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 13, 1883  
 7. AGE YEARS 56 MONTHS 0 DAYS 8 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper  
 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) Independence (STATE OR COUNTRY) Mo.  
 FATHER 13. NAME J W Lawrence  
 14. BIRTHPLACE (CITY OR TOWN) Memphis (STATE OR COUNTRY) Tenn.  
 MOTHER 15. MAIDEN NAME William Reed  
 16. BIRTHPLACE (CITY OR TOWN) no Record (STATE OR COUNTRY) .....  
 17. INFORMANT Mrs. W. E. Rihm (ADDRESS) Quindaro, Okla.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Galena, Kas DATE 7-22 1939  
 19. FUNERAL DIRECTOR (NAME) Allison Undertaker (ADDRESS) Galena, Kansas  
 20. FILED 7-21 1939 E. J. Jones Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 21 1939  
 22. I HEREBY CERTIFY, That I attended deceased from July 1939, to July 21, 1939. I last saw her alive on July 21, 1939. Death is said to have occurred on the date stated above, at 2:30 p.m. The principal cause of death and related causes of importance were as follows:  
Cholecystitis  
- toxaemia - Cancer of liver & gall bladder -  
 Other contributory causes of importance:  
 Name of operation Cholecystomy Date of July 1939  
 What test confirmed diagnosis? ..... 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) Theo. C. Frost M. D.  
 (Address) Jasper, Mo.

K. 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.

45

RECEIVED

District Health Officer No. 6,

District File Number 839-1654

Date Filed AUG 10 1939

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 con with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

25-899  
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 411  
 (b) Township..... Primary Registration District No. 2007 Registered No.....  
 (c) City Juplin (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 Mamie Shields

(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) Widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-1 1937

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

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19...  
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hrs. or .....min.  
36 0 8

stroke following chole-  
cytistomy - cancer  
of liver and gall  
bladder  
46

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.....

Other contributory causes of importance:

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

unknown as to  
primary  
operation cholecystectomy Date of.....  
 What test confirms diagnosis?..... Was there an autopsy?.....

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

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

17. INFORMANT (ADDRESS)

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.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

Manner of injury.....  
 Nature of injury.....

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify.....  
 (Signed) A Mitchell Gregg, M. D.  
 (Address).....

20. FILED..... 19..... Local Registrar.

SUPPLEMENT

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

1939

S-25897