

SEP 6 1939

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

29288  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Nemour Registration District No. 385  
 (b) Township 1 Primary Registration District No. 55-3-6  
 (c) City Willow Spg (d) Street No. 4278 St.  
 (e) Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. (f) How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.  
 2. PRINT FULL NAME John O Smith  
 (a) Residence, No. ALDEN 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Althea Smith  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 24, 1877  
 7. AGE YEARS 62 MONTHS 3 DAYS 7 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 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) Germany (STATE OR COUNTRY) Boonville, Mo  
 FATHER 13. NAME Lou Smith 14. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY) Mo  
 MOTHER 15. MAIDEN NAME Annie Fromme 16. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY) Mo  
 17. INFORMANT (ADDRESS) Charles K Smith Willow Springs Mo  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Wesley Cem DATE Sept 1, 1939  
 19. FUNERAL DIRECTOR (NAME) Burns & Son (ADDRESS) Willow Springs, Mo  
 20. FILED 8-31- 1939 Manette Ferguson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 31, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1939, to Aug 31, 1939.  
 I last saw him alive on Aug 28, 1939. Death is said to have occurred on the date stated above, at 2:00 p.m.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral Haemorrhage  
 Date of onset  
 Other contributory causes of importance: HTN  
 Name of operation \_\_\_\_\_ 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) Stovall M. D.  
 (Address) Willow Springs, Mo  
345

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 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.

**RECEIVED**

District Health Officer No. 5,

District File Number 9 39 133

Date Filed 9/39

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.