

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

32944
Do not use this space.

1. PLACE OF DEATH **DEAD**
 (a) County Marion Registration District No. 547
 (b) Township Mason Primary Registration District No. 3029
 (c) City Mannibal (d) Street No. Levering 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 432 Frances Lillian Childs
 (a) Residence, No. 114 - 20th Street 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 25, 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 1 6

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 31, 1939

I HEREBY CERTIFY, That I attended deceased from July 2, 1939, to Aug 31, 1939
 I last saw her alive on Aug 31, 1939 Death is said to have occurred on the date stated above, at 5:50 P.M.
 The principal cause of death and related causes of importance were as follows:
Pneumonia
 Date of onset ?

Other contributory causes of importance:
Myocardial infarction

Name of operation operectomy Date of Aug 3
 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? No
 If so, specify _____
 (Signed) W. H. Fisher, M. D.
 (Address) Mannibal, Mo.

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

13. NAME Thomas Leo Riney

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

15. MAIDEN NAME Mary Jane Parsons

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

17. INFORMANT Charles I Childs
 (ADDRESS) 114 - 20th

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Grandview DATE 9/2/39

19. FUNERAL DIRECTOR (NAME) Smiths' Funeral Home
 (ADDRESS) Mannibal Missouri

20. FILED Sept 6 1939 W. H. Fisher
 Local Registrar

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

D. W. Fisher

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(Licensed Embalmer's Statement on Reverse Side)

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.....

J.H. Marsh L.E. 3932

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Crawford Smith

Licensed Embalmer No..... 3814.....

P. O. Address..... Hannibal Mo.....

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.