

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

Dr. Ned White

43394
Do not use this space.

1. PLACE OF DEATH
 (a) County GREENE Registration District No. 318
 (b) Township 1 Primary Registration District No. 2001
 (c) City SPRINGFIELD (d) Street No. 1902 Washington 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 530 Myrtle Frances Smith
 (a) Residence, No. 1902 Washington 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Thomas H. Smith</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 8, 1883</u>		
7. AGE YEARS <u>7 56</u>	MONTHS <u>5</u>	DAY <u>12</u>
If LESS than 1 day, hrs. or min.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>	
	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
FATHER	12. BIRTHPLACE (CITY OR TOWN) <u>Sheffield</u> (STATE OR COUNTRY) <u>Alabama</u>	
	13. NAME <u>James Holland</u> 14. BIRTHPLACE (CITY OR TOWN) <u>Texas</u> (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME <u>Mollie</u>	
	16. BIRTHPLACE (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY)	
17. INFORMANT <u>Dempsey W. Smith</u> (ADDRESS) <u>Springfield, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Greenlawn</u> DATE <u>Dec. 22</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) <u>H. H. Lohmeyer</u> (ADDRESS) <u>Springfield, Mo.</u>		
20. FILED <u>12/21</u> 19 <u>39</u> <u>Chas. H. George M. D.</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 20, 1939
 22. I HEREBY CERTIFY, That I attended deceased from Oct, 1935, to Dec 19, 1939
 I last saw him alive on Dec 19, 1939. Death is said to have occurred on the date stated above, at 12.30 a.m.
 The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage

Date of onset
12-19
39

9562

Other contributory causes of importance:
Hypertensive Cardiovascular Disease

Name of operation none Date of
 What test confirmed diagnosis? Clinical Was there an autopsy? no

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) Ned White, M. D.
 (Address) Springfield

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Paul F. Lohmeyer

Licensed Embalmer No.

2457

P. O. Address.....

Mayfield

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.

X