

FEB MAR 12 1940

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

6633  
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE / Registration District No. 318  
(b) Township \_\_\_\_\_ Primary Registration District No. 2001 Registered No. 154  
(c) City SPRINGFIELD (d) Street No. \_\_\_\_\_ City 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

232 SAM BOSTIC  
(a) Residence, No. 855-N-Summit 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 colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) -Feb-22-1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
> 75 11 21

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Janitor  
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) Van Buren Arkansas

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

MOTHER 15. MAIDEN NAME 9

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 9

17. INFORMANT (ADDRESS) Mrs. Savanna Smith  
855-N-Summit

18. BURIAL, CREMATION, OR REMOVAL PLACE Hazelwood DATE -2-16- 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H.V. Smith  
702-N-Jefferson

20. FILED 2/16/40 19 Chas. A. George M.D.  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 13 - 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 24, 1940, to Feb 12, 1940  
I last saw h. alive on February 12, 1940. 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:

Chronic Intestinal Neoplasia  
Date of onset 1931  
Other contributory causes of importance: Ulcerated Stricture of Esophagus

Name of operation Superficial Esophagectomy Date of Feb-4-40  
What test confirmed diagnosis? \_\_\_\_\_ 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) James B. Plunk M. D.  
(Address) 2001 N Summit

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD  
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.....

*Herbert V Smith*

Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Herbert V Smith*

Licensed Embalmer No.....

*3324*

P. O. Address.....

*702-N. Jefferson*

**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.**

*✓*

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 66337  
Registrar's No. 154

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Aspy field  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Anna Kotic

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m

5. Color or race B

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 4-26-40 (b) W. E. Naudley MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 13 - 40  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Chr. Int. Nephritis  
Cystitis  
Urethral stricture

Other conditions (Include pregnancy within 3 months of death)

Major findings Of operation Suprapubic 2-7-40  
Cystotomy - to relieve  
Of autopsy obstruction to bladder  
from urethral stricture

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (e) Means of injury \_\_\_\_\_

23. Signature James B. Clark (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

