FILED APR 1 1940

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

11518
Do not use this space.

1. PLACE OF DEATH
(a) County Lawrence Registration District No. 471
(b) Township Pierce Primary Registration District No. 4284 Registered No. 4
(c) City Pierce City (d) Street No. The Pierce City Clinic 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 310 Gertrude Smith Stapp
(a) Residence, No. Pierce City 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 Ray Stapp
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 8 1901
7. AGE YEARS 38 MONTHS 4 DAYS 2 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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 20

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stotts City Mo

FATHER
13. NAME Arch Smith
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stotts City Mo

MOTHER
15. MAIDEN NAME Pearl Carver
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Phelps Mo

17. INFORMANT (ADDRESS) Mr. Pearl Smith
18. BURIAL, CREMATION, OR REMOVAL
PLACE City Cemetery DATE Jan 12 1940
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm Wessell Jr Pierce City Mo
20. FILED Jan 12 1940 E. B. Wright Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 10, 1940
22. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1937, to Jan. 10, 1940
I last saw her alive on Jan. 10, 1940. Death is said to have occurred on the date stated above, at 8 p m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Preeclamptic Toxaemia (Puerperal)	Dec 20
Puerperal Nephritis	Dec 20
Terminal Pulmonary Edema	Jan. 9

Other contributory causes of importance:

Chronic Bronchial Asthma	38 yrs
Hyperthyroidism (Toxic)	13 yrs

Name of operation None Date of
What test confirmed diagnosis? Clinical Was there an autopsy?
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No 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) L Mason Lyons, M. D.
422 (Address) Pierce City Mo

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 6,

District File Number 340-898

Date Filed MAR 25 1940

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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 [illegible] Jr.

Licensed Embalmer No. 1512

P. O. Address Pierce City 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.

o. 2B
-21-40
X22059

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11578

Registration District No. 471 Primary Registration District No. 4284 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Pierce City
(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 (Specify whether years, months or days)
In this community

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.

3. (a) PRINT FULL NAME Gertrude Smith Stapp

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

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

8. AGE: Years 38 Months 4 Days 2 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19, to 19; that I last saw h. alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Pre Eclamptic Toxemia Puerperal

Due to Puerperal nephritis

Due to Terminal Pulmonary Edema

Other conditions 146
(Include pregnancy within 3 months of death)
Chr. Bronchial asthma

Major findings:
Of operations Hyperthyroidism
Premature delivery - twins - 6 weeks prior to death
(Jan. 3, 1940)

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 L. Mason Lyon M.D. (or other)
Address Pierce City Date

11518 (1940)