

Registration District No. 470

Primary Registration District No. 5633

Registrar's No. 133

NOV 20 1940

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Mount Vernon  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri State Sanatorium 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 646 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell  
(c) City or town Mountain View 8  
(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 Ella Marie Smalley

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. Not known

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Virgil O. Smalley 6. (c) Age of husband or wife if alive Not known years

7. Birth date of deceased October 17 1905  
(Month) (Day) (Year)

8. AGE: Years 35 Months \_\_\_\_\_ Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation School Teacher

11. Industry or business 1

MOTHER FATHER { 12. Name James W. Dixon

18. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Katie Agnes Cauley

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

16. (a) Informant Ethel McMichael, Record Clerk

(b) Address Missouri State Sanatorium

17. (a) Removal (b) Date thereof Oct 26-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mountain View, Mo

18. (a) Signature of funeral director Forsyth Funeral Home

(b) Address Mount Vernon, Mo

19. (a) 10-25-40 (b) P. A. HOLMES  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25  
year 1940 hour 9:00 minute \_\_\_\_\_ P. A. M.

21. I hereby certify that I attended the deceased from Jan. 19 1939 to Oct. 25 1940

that I last saw him 34 alive on October 25 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 2 1/2 yrs

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 77  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? Yes

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

23. Signature [Signature] (M. D. or other) 1

Address Not Given, Mo Date signed 10/26/40

Duration

2 1/2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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.....

*Max Fossett*

Registered Apprentice No. *268*

working under my personal supervision.

Signed.....

*Max H. S. Fossett*

Licensed Embalmer No. *2720*

P. O. Address *W. V. Venable*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**