

NOV 24 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

37013
Do not use this space.

1. PLACE OF DEATH
(a) County Ray Registration District No. 742
(b) Township Palh Primary Registration District No. 5-9772 Registered No. _____
(c) City Lawson Mo (d) Street No. _____ 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 James Elmore Smith
(a) Residence, No. Ray Co. Lawson Mo. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) No.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 24, 1920
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
18 10 7
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. none
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) Lawson Mo

13. NAME James Sidney Smith

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lawson Missouri

15. MAIDEN NAME Fauntine Elmore

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

17. INFORMANT (ADDRESS) W.R. Morrow

18. BURIAL, CREMATION OR REMOVAL PLACE Lawson Mo DATE 11-1 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Morand + Males
Lawson Mo.

20. FILED Nov. 1 1939 Edwin S Rowse
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 31 1939
22. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1939 to Oct. 31 1939
I last saw him alive on Oct. 31 1939. Death is said to have occurred on the date stated above, at 1:15 A.M.
The principal cause of death and related causes of importance were as follows:

left lobar Pneumonia Date of onset Oct 25
Septicemia Sept 30
Streptococic sore throat Oct 15

Other contributory causes of importance: 11A

Name of operation _____ 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? No
If so, specify _____
(Signed) Oct 25 1939 _____, M. D.
(Address) Lawson Mo.

MARGIN RESERVED FOR BINDING

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

V. S. NO. 2. 5016-1-12-38 I X14028

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.

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 11/7/39

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 James A. Moles

Licensed Embalmer No. 3296

P. O. Address Excelsior Springs, 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.