

SEP 12 1939 73
Registration District No. _____

Primary Registration District No. 300-6

Registrar's No. 166

1. PLACE OF DEATH: BOONE
(a) County BOONE
(b) City or town COLUMBIA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 506 HICKMAN AVE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County BOONE
(c) City or town COLUMBIA
(If outside city or town limits, write "RURAL")
(d) Street No. 506 HICKMAN
(If rural, give location)
(e) If foreign born, how long in U. S. A. 7 _____ years.

8. (a) PRINT FULL NAME JERRY STIDHAM
33
8. (b) If veteran, name war BABE
8. (c) Social Security No. BABE

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 14th
year 1939 hour 10 minute 50 P. M.

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced BABE
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased AUGUST L 14th 1939
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7-13-1939 to 8-14-1939
that I last saw him alive on 8-14-1939
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
X X X hr. 30 min.

Immediate cause of death
Signature
Due to 154
Due to _____

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation _____

11. Industry or business None

Major findings: Of operations no
Of autopsy no

MOTHER FATHER
12. Name EARL STIDHAM
13. Birthplace VANLEER KY
(City, town, or county) (State or foreign country)

14. Maiden name JANIE COPLEY
15. Birthplace WEST VA
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Earl Stidham
(b) Address 506 HICKMAN AVE

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence no
(c) Where did injury occur? no
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

17. (a) BURIAL (b) Date thereof Aug 15th 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Providence

18. (a) Signature of funeral director R. O. Willett
(b) Address COLUMBIA

While at work? (Specify type of place)
(e) Means of injury
23. Signature W. R. Dyroot (M. D. or other)
Address Columbia Date signed 8-15-39

19. (a) 8/15/39 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

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

REF. 1 X1931

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.