

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3269

Registration District No. 647

Primary Registration District No. 5857

Registrar's No.

1. PLACE OF DEATH:
(a) County Ozark 2
(b) City or town Bayou View
(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 In this community years, months or days) 2 21

3. (a) PRINT FULL NAME Columbus M. Lester
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years 5 1883
7. Birth date of deceased MAY 5 1883 (Month) (Day) (Year)

8. AGE: Years 57 Months 3 Days 1 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business
12. Name JAMES P. LESTER
13. Birthplace Missouri (City, town, or county) (State or foreign country)
14. Maiden name SARAH AUSTIN
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. S. GALBRAITH
(b) Address Bakersfield, Mo.
17. (a) Burial (b) Date thereof Feb 5 1940 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bakersfield

18. (a) Signature of funeral director HIGGINBOTHAM
(b) Address Funeral Service
19. (a) (Date received local registrar) SALEM, ARK 55 (b) Registrar's signature

2/6/40 C. G. Beach (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County OZARK
(c) City or town Bakersfield (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.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 4 year 1940 hour 4 minute 10 P. M.
21. I hereby certify that I attended the deceased from Feb 3 1940 to Feb 3 1940 that I last saw him alive on Feb 3 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Encephaloid Gastric Cancer
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
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?
While at work? (Specify type of place) (a) Means of injury

23. Signature J. H. P. Stark M.D. (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)
Address Bakersfield, Mo. Date signed 2/11/40

RECEIVED

District Health Officer No. 6,

District File Number 240-599

Date Filed FEB 20 1940

No record of Physician

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

3269
Do not use this space.

1. PLACE OF DEATH

(a) County Osark Registration District No. 647
(b) Township Wayne Primary Registration District No. 2857 Registered No. _____
(c) City _____ (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Columbus M. Lester
(a) Residence, No. _____ 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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (use the word) 2

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 5-5-1883

7. AGE YEAR 50 MONTHS 8 DAYS 19 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
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. _____
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) _____

FATHER
13. NAME _____

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

MOTHER
15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19 CA Beach Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 4 1980

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h_____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 J. H. R. Starr M. D.
(Signed) Bakersfield (Address) mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

State of Missouri, 1980. This is a preliminary statement of occurrence and may be properly classified. Exact statement of occurrence is very important.

S-3269