

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

I X 16933

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.

FILED APP 8 1940

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

10155
Do not use this space.

1. PLACE OF DEATH

(a) County Boss Registration District No. 73
 (b) Township Columbia Primary Registration District No. 3006
 (c) City Columbia (d) Street No. Noyes Hospital 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 76 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

CHARLES MADISON
 (a) Residence, No. 11 - North 3 st. 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 Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) about 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
about 76

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at home
 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) Columbia MO

FATHER
 13. NAME dont know

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

MOTHER
 15. MAIDEN NAME dont know

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

17. INFORMANT (ADDRESS) Robert Madison Columbia Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Columbia DATE 3-21 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Stuart E. Parker
Professor Meserve

20. FILED 3/21 1940 Allie Selby Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 19 1940

22. I HEREBY CERTIFY, That I attended deceased from March 16 - 1940, to Mar 19 - 1940

I last saw him alive on March 19, 1940. Death is said to have occurred on the date stated above, at 2:55 Am.
 The principal cause of death and related causes of importance were as follows:

Pneumonia lobes lower rt. lobe
198
 Other contributory causes of importance: Arterio Sclerosis & large heart

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 _____
 (Signed) Dr. Stone M. D.
 (Address) Columbia

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

Sharon P. Parker

Licensed Embalmer No. *2900*

P. O. Address. *Columbia, W*

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.