

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

17829
Do not use this space.

1. PLACE OF DEATH
 (a) County Bacon Registration District No. 73
 (b) Township Columbia Primary Registration District No. 3006
 (c) City Columbia (d) Street No. The Ellis Fischel State Cancer Hospital Registered No. 106
 (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 Betty Mayberry
 (a) Residence, No. Odessa, Mo. 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 <u>F</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or WIFE OF) <u>Forest Mayberry</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Mar. 31 1900</u>				
7. AGE	YEARS <u>40</u>	MONTHS <u>1</u>	DAYS <u>16</u>	IF LESS than 1 day,hrs. ormin.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>House wife</u>			
	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) <u>Missouri</u>				
FATHER	13. NAME <u>Si Thomas</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Odessa Missouri</u>			
MOTHER	15. MAIDEN NAME <u>Georgia Turner</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Odessa Missouri</u>			
17. INFORMANT (ADDRESS) <u>Hospital Record</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Odessa Cem.</u> DATE <u>5-19-1940</u>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>W. W. ...</u>				
20. FILED <u>5/17/40</u> <u>Allie Selby</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH	
21. DATE OF DEATH (MONTH, DAY, AND YEAR)	<u>5-17-1940</u>
22. I HEREBY CERTIFY, That I attended deceased from <u>5-16-40</u> , 19 <u>40</u> , to <u>5-17-40</u> , 19 <u>40</u> I last saw her alive on <u>5-17-40</u> , 19 <u>40</u> Death is said to have occurred on the date stated above, at <u>3:15 pm</u> . The principal cause of death and related causes of importance were as follows: <u>Tumor of abdomen (nervous system) - malignant</u> <u>Post operative shock</u>	
Other contributory causes of importance:	<u>Cirrhosis of Liver</u> <u>Incarcerated hernia</u>
Name of operation	<u>Laparotomy for tumor</u> Date of <u>5-17-40</u>
What test confirmed diagnosis?	<u>Autopsy</u> Was there an autopsy? <u>Yes</u>
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? <u>No</u> If so, specify _____ (Signed) <u>Eugene M. Bricker</u> , M. D. (Address) <u>Columbia, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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.

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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..... *L. C. Weinstein*.....
Licensed Embalmer No. *433*.....
P. O. Address..... *Obasa, Md.*.....

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.

MISSOURI STATE BOARD OF HEALTH
DEPARTMENT OF COMMERCE
STANDARD CERTIFICATE OF DEATH
BUREAU OF THE CENSUS

State File No. **17829**
Registrar's No. _____

Registration District No. **Boone 73** Primary Registration District No. **3006**

HOWENA MOORE

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

1. PLACE OF DEATH:

(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:
(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)

3. (a) PRINT FULL NAME

Bettie Mayberry

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **7** 5. Color **cel** race _____
6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years **40** Months **1** Days **16** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 **2** day **17** year **1948** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Tumor of abdomen (malignant) of greater omentum** Duration _____
Post operative shock

Other conditions **Cirrhosis of Liver** (Include pregnancy within 3 months of death)

Major findings: **Regenerated femoral tumor** PHYSICIAN _____
Laparotomy for the cause to which death should be charged statistically.

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) (e) Means of injury _____

23. Signature **Eugene M. Bricker** other _____
Address **Columbia** Date signed _____

SUPPLEMENTAL

5-17829