No. 2
10-39
17-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21198

FILED JUL 9 1940

Registration District No. 73 — Primary Registration District No. 3006 — Registrar's No. 138

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: White Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: all of life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Boone.
(c) City or town: Columbia
(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.

3. (a) PRINT FULL NAME: Julia A. Wade.
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Female
5. Color or race: W.
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Wm Wade.
6. (c) Age of husband or wife if alive: ✓ years
7. Birth date of deceased: October (Month), 19 (Day) - 1875 (Year)
8. AGE: Years 64 | Months 8 | Days 7. | If less than one day ____ hr. ____ min.
9. Birthplace: Boone County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Invalid.
11. Industry or business: ✓
FATHER
12. Name: John Henry Asbury.
13. Birthplace: Boone County (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name: Elizabeth Waters.
15. Birthplace: Boone County (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Josephine Beiswinger,
(b) Address: Columbia Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-28-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Hickory Grove Cem.
18. (a) Signature of funeral director: Parker's - (W.V.W.)
(b) Address: Columbia, Mo.
19. (a) 6/28/40 (Date received by local registrar) (b) Allie Selby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26th year 1940 hour 9 minute 30 P. M.
21. I hereby certify that I attended the deceased from July 25th 1940 to June 26 1940 that I last saw her alive on June 25 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Right Hemiplegia of Brain — Duration: 2 days
Due to: ____
Due to: General Arteriosclerosis
Other conditions (Include pregnancy within 3 months of death): ____
Major findings: Of operations: ____ Of autopsy: ____

PHYSICIAN — Underline 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? ____ (Specify type of place)
While at work: ____ (e) Means of injury: ____
23. Signature: Stephen D. Hunt (M. D. or other)
Address: Columbia Date signed: June 26

(Licensed Embalmer's Statement on Reverse Side)

828

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 W. V. Whitmiles

Licensed Embalmer No. 3893

P. O. Address Calumpsill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21/98

Registration District No. 73 Primary Registration District No. 3006 Registrar's No.

SUPPLEMENTARY

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)

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.

3. (a) PRINT FULL NAME Julia A. Wade

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

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

8. AGE: Years 64 Months 8 Days 7 If less than one day min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 26
year 1940 hour minute M.

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

Immediate cause of death Right Hemiplegia of brain

Due to High blood pressure
Previous stroke (SPS)

Due to General arteriosclerosis

Other conditions
(Include pregnancy within 3 months of death)

$2 W

Major findings:
Of operations

Of autopsy

Duration

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

23. Signature Stephen D. Smith (M. D. or other)
Address Columbia Mo Date signed