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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27905

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 177

1. PLACE OF DEATH:

BOONE

(a) County
(b) City or town COLUMBIA
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BOONE COUNTY HOSPITAL
(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 CALIFORNIA (b) County
(c) City or town SAN FRANCISCO
(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? LIFE years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG. day 17th
year 1940 / hour 4 30 minute A M.
21. I hereby certify that I attended the deceased from July 10 1940 to Aug 17 1940
that I last saw her alive on Aug 16 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Fracture cervical vertebra with dislocation & severed spinal cord
Due to: 7/10
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations NO
Of autopsy NO
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) Auto Accident
(b) Date of occurrence 7-10-40
(c) Where did injury occur? 1540 Boone MO
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
74 No
While at work: No (Specify type of place) (e) Means of injury
23. Signature: [Signature] M. D. or other
Address: [Address] Date signed 8/17/40

3. (a) PRINT FULL NAME MISS MARY KESSLER 246
(b) If veteran, name war NO
(c) Social Security No.

4. Sex FEMALE
5. Color or race W.
6. (a) Single, widowed, married, divorced SINGLE
(b) Name of husband or wife SINGLE
(c) Age of husband or wife if alive XX years

7. Birth date of deceased AUGUST 1st 1908
(Month) (Day) (Year)

8. AGE: Years 32 Months x Days 16
If less than one day hr. min.

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

10. Usual occupation BOOK KEEPER

11. Industry or business

MOTHER FATHER { 12. Name MORRIS KESSLER
13. Birthplace HUNGARY
(City, town, or county) (State or foreign country)
14. Maiden name HANNA MOSKOWITZ
15. Birthplace HUNGARY
(City, town, or county) (State or foreign country)

16. (a) Informant J. A. Golushky
(b) Address San Francisco, Calif.

17. (a) REMOVAL (b) Date thereof AUG 18 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation DENVER COLO.

18. (a) Signature of funeral director [Signature]

(b) Address COLUMBIA MO.

19. (a) 8/17/40 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

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

FELDMAN FUNERAL HOME
DENVER COLORADO

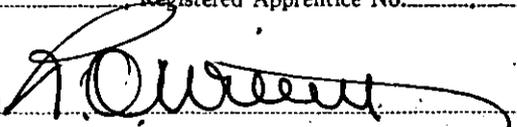
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

working under my personal supervision.

Registered Apprentice No.

Signed 

Licensed Embalmer No. 3183

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27905-**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **73**

Primary Registration District No. **3006**

Registrar's No.

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 _____ (Specify whether)
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 **Miss Mary Kessler**

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 **B**

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 **32** Months _____ 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 _____

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) _____ (Registrar's signature)

20. DATE OF DEATH Month **8** day **17** year _____ 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 **Fracture cervical vertebrae & severed spinal cord**

Due to **Auto accident July 10, 1940**

Other conditions. (Include pregnancy within 3 months of death) _____

Major findings: Of operations **210 yr 24** 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) **Accident**
(b) Date of occurrence **July 10, 1940**
(c) Where did injury occur? **US Highway 40 Boone**
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? **No** (Specify type of place) (e) Means of injury **Truck collision**

23. Signature **W. A. Roberts** (M. D. or other) _____ Address **Columbia Mo** Date signed _____

SUPPLEMENTARY

