

Registration District No.

73

Primary Registration District No.

3006

Registrar's No.

202

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: NO 2
(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

8. (a) PRINT FULL NAME

BENJAMINE M. SHEETS 321

8. (b) If veteran,

name war SPANISH AM.

3. (c) Social Security

No. X

4. Sex

MALE5. Color or race WHITE6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife

MARGARETE SHEETS

6. (c) Age of husband or wife if

alive 71 years

7. Birth date of deceased

Sept. 28th 1869
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

701112

hr.

min.

9. Birthplace

Galloway Co
(City, town, or county)MISSOURI
(State or foreign country)

10. Usual occupation

FARMER

11. Industry or business

MOTHER FATHER

12. Name CLAY SHEETS

13. Birthplace

DONT KNOW 9
(City, town, or county) (State or foreign country)

14. Maiden name

DONT KNOW 9
(City, town, or county) (State or foreign country)

15. Birthplace

DONT KNOW 9
(City, town, or county) (State or foreign country)

16. (a) Informant

Hubert Sheets

(b) Address

COLUMBIA

17. (a)

BURIAL

(Burial, cremation, or removal)

(b) Date thereof

Sept 11-40
(Month) (Day) (Year)

(c) Place: burial or cremation

CITY CEM. FULTON MO

18. (a) Signature of funeral director

R. A. Willett

(b) Address

Columbia, Mo

19. (a)

9/11/40
(Date received local registrar)

(b)

Allie Selby
(Registrar's signature)

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. 603 N. 7th St
(If rural, give location)
- (e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 10th
year 1940 hour 2:40 minute A. M.

21. I hereby certify that I attended the deceased from Sept 10
1940 to Sept 10 1940

that I last saw him alive on Sept 10 1940

and that death occurred on the date and hour stated above.

Immediate cause of death Paralysis

Duration

Due to Hard. of Arteries

Due to _____

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 sta-
tistically.

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? 96

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signature A. G. Bradford (M. D. or other) 1Address Columbia, Mo Date signed 9/11/40

82A

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 Keith Collier

Licensed Embalmer No. 3632

P. O. Address Columbia Mission

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. 21929

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. _____

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 Benjamin M. Sheets

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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 Months Days If less than one day min.
70 11 12

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) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 10 year 1940 hour _____ minute _____ M.

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

Immediate cause of death Paralysis Duration _____

Due to Hardening of arteries

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations 72k

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) (e) Means of injury _____

23. Signature H.A. [unclear] (M, D. or other)

Address Columbia Mo. Mo. Date signed 9/30/40

Supplemental Entry

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

