

Registration District No. 73

Primary Registration District No. 5112

Registrar's No. 169

1. PLACE OF DEATH:

(a) County Boone County
(b) City or town Rural Route # 6
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community 44 years, months or days

3. (a) PRINT FULL NAME Orpha Alice Mayes

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mayes Vincel 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Jan. 11, 1895
(Month) (Day) (Year)

8. AGE: Years 45 Months 6 Days 28 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name William Childers
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Orpha Alice Mayes
(b) Address R.F.D. # 6 Columbia, Mo

17. (a) Burial (b) Date thereof August 11, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memoria Park Cem

18. (a) Signature of funeral director L. F. M. ...
(b) Address Boonville Mo

19. (a) 8/10/40 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone
(c) City or town R.F.D. # 6 Columbia, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. # 6
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9th. day August
year 1940 hour 1:00 minute A 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 _____

A severe H. e. m. o. r. a. g. e. of the lung
Due to lung H. e. m. o. r. a. g. e.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy none

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 M. P. ... (City, town, or county)
Address Columbia, Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo

28
P

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 Carl W. Hause

Licensed Embalmer No. 3955

P. O. Address Boonville, Mo

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **27939**

Registration District No. **73**

Primary Registration District No. **5712**

Registrar's No. **169**

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

1. PLACE OF DEATH:

(a) County... **Boone**
 (b) City or town... **Columbia T.P.**
(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 years, months or days)

3. (a) PRINT FULL NAME

Alpha Alice Mayes

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **7** 5. Color or race **W** 6. (a) Single, widowed, 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 **45** Months **6** Days **28** If less than one day hr. min.

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

10. Usual occupation...

11. Industry or business...

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) (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)

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. MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Aug** day **9** year **1940** 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... **Severe Hemorrhage the lung.**
Lung Hemorrhage
 Due to... **N.M.D.**
 Other conditions... (Include pregnancy within 3 months of death)

Major findings: Of operations... **23**
 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 **W.R. Tolson** (M.D. or Other)
 Address **Columbia** signed

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

SUPPLEMENTAL REPORT

