. No. 2
-11-10-39
5-17-39
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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. 31382

FILED OCT 11 1940

Registration District No. 73 Primary Registration District No. 3006 Registrar's No. 207

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: Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 Days. (Specify whether years, months or days)

In this community 15 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper

(c) City or town Boonville
(If outside city or town limits write "RURAL")

(d) Street No. Sycamore St
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME Tom E Smith

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Male

5. Color or race Black

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

6. (b) Name of husband or wife Emma Smith

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Aug (Month) 1 (Day) 1865 (Year)

8. AGE: Years 75 Months 1 Days 18 If less than one day ____ hr. ____ min.

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

10. Usual occupation Yard Man

11. Industry or business Cleaning Co.

MOTHER FATHER

12. Name James Smith

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

14. Maiden name Louise Smith

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

16. (a) Informant Office Cancer Hospital

(b) Address Columbia Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20 1940 (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Hebedyman Bell

(b) Address Boonville Mo.

19. (a) 9/20/40 (Date received local registrar) (b) Allie Selby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 19 year 1940 hour 5:45 AM minute ____ M.

21. I hereby certify that I attended the deceased from 9-4-40, 19__, to 9-19, 1940; that I last saw him alive on 9-18-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	5 days
Carcinoma of Stomach	?
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations Carcinoma of Stomach
Of autopsy Bronchopneumonia

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)

(e) Did while at work? (e) Means of injury

23. Signature Eugene M Brickey (M. D. or other) M.D.

Address Ellis Fischel Cancer Hosp Date signed 9-19-40

(Licensed Embalmer's Statement on Reverse Side)

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: G. F. Boller

Licensed Embalmer No. 3069

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.