

NOV 15 1940

STANDARD CERTIFICATE OF DEATH

State File No. 34769

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 230

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 26 days
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan
(c) City or town Florence, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. R #1, Box 80
(If rural, give location)
(e) If foreign born, how long in U. S. A. — years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 23
year 1940 hour 8 minute 07 A.M.

21. I hereby certify that I attended the deceased from September 27, 1940 to October 23, 1940,
that I last saw her alive on October 23, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration 5 days

Due to Post operative atelectasis 6 days

Due to Carcinoma of stomach 4 months

Other conditions 4/6
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of stomach
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?
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While at work? (Specify type of place) (e) Means of injury

23. Signature Louis P. Kirby (M. D. or other) Dr. D.
Address Ellis Fischel Hosp. Date signed 10/23/40

3. (a) PRINT FULL NAME MICHALKOWSKY, THERESA A.

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 Widow

6. (b) Name of husband or wife Ardinand 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased May 3 1872
(Month) (Day) (Year)

8. AGE: Years 68 Months 5 Days 20 If less than one day — hr. — min.

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

10. Usual occupation Housewife

MOTHER FATHER

11. Industry or business —

12. Name August Brien

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

14. Maiden name Theresa Langhals

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

16. (a) Informant Hospital Records

(b) Address Columbia, Mo.

17. (a) Burial (b) Date thereof Oct 25 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Florence Morgan Co.

18. (a) Signature of funeral director W. J. K... ..

(b) Address Versailles, Mo.

19. (a) 10/23/40 (b) Allie Salby
(Date received local registrar) (Registrar's signature)

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

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3
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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 _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

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.