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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38110**

Registration District No. **73**

Primary Registration District No. **3006**

Registrar's No. **246**

1. PLACE OF DEATH: **3006**

(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**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Boone**

(c) City or town **Columbia**
(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 FULLNAME **ORA MAY JAPP**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **10**
year **1940** hour **10:30** minute **0** M.

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

21. I hereby certify that I attended the deceased from **11/16**, 19**40**, to **Nov 15**, 19**40**
that I last saw her alive on **Nov 15**, 19**40**
and that death occurred on the date and hour stated above.

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

Immediate cause of death **Carcinoma of rectum**
Left hip joint & thigh

6. (b) Name of husband or wife **FRANK M JAPP** 6. (c) Age of husband or wife if alive _____ years
22 (Day) **1897** (Year)

Due to **N.M.D.**

Due to _____

8. AGE:	Years	Months	Days	If less than one day
	43	5	23	hr. _____ min. _____

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

9. Birthplace **Boone County Mo**
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____

Of autopsy: **None**

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

10. Usual occupation **AT HOME**

11. Industry or business _____

12. Name **OWEN SMITH**

13. Birthplace **Boone County Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **HENRIETTA COMER**

15. Birthplace **Calhoun County Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **FRANK M. JAPP**

(b) Address **822 RANSHINE Columbia Mo**

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

(c) Place: burial or cremation **MEMORIAL PARK Columbia Mo**

18. (a) Signature of funeral director **Paula Parmenter**

(b) Address **Columbia Mo**

19. (a) **11/18/40** (b) **Allice Delby**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **NO**

(b) Date of occurrence **None**

(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? **NO**
While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature **W.P. Dyck** (M. D. or other) **1**
Address **Columbia Mo** Date signed **11-16-40**

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

MOTHER FATHER

JAN 7 - 1943

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

M. N. Whitcomb

Licensed Embalmer No. *3893*

P. O. Address..... *Calumet*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.