

No. 2
1-4-41
1-17-39
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19507
State File No. ~~1-17-39~~

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 73 Primary Registration District No. 3006 Registrar's No. 121

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 Willits Convalescent Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months (Specify whether years, months or days)
In this community Entire Life

3. (a) PRINT FULL NAME AMANDA FLORENCE ANGELL
3. (b) If veteran, name war None 3. (c) Social Security No. None

5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive 4 years
7. Birth date of deceased July (Unknown) 1860
(Month) (Day) (Year)

8. AGE: Years 80 Months 10 Days Unknown If less than one day hr. min.

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

10. Usual occupation Retired School Teacher

11. Industry or business

12. Name Wallace Angell
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Mildred Haggard
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant M. C. Haggard

(b) Address Mexico, Mo

17. (a) Burial (b) Date thereof May 8 '41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Springfield, Mo

18. (a) Signature of funeral director Stanger

(b) Address Columbia, Mo

19. (a) 5/8/41 (b) Allee Selby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Sturgeon
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 7
year 1941 hour 4 minute 20 P. M.

21. I hereby certify that I attended the deceased from 4 to 7 1941
10 - 1941 to 5 - 7 - 1941
that I last saw her alive on 5-6-41 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration few
or less hrs

Due to Arteriosclerosis

Due to hypertension

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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) No

(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? No

While at work? (Specify type of place) (d) Means of injury

23. Signature W. D. Dyson (M. D. or other)

Address Columbia, Mo Date signed 5-8-41

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

MOTHER FATHER

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. 41312

P. O. Address Columbia, 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, fact should be so stated above.