

No. 2  
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5-17-39  
I-X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED OCT 21 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31039

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 260

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

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia, Mo.

(c) Name of hospital or institution Bellevue Convalescent Home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 years  
(Specify whether In this community Patrol Home years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town Rockport  
(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 FULL NAME LOVELLA ANGELL

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

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

6. (b) Name of husband or wife Frank Sidding Angell 6. (c) Age of husband or wife if alive Reverend years

7. Birth date of deceased Oct. 10, 1854  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>86</u>	<u>11</u>	<u>12</u>	hr. min.

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

10. Usual occupation Homemaker

11. Industry or business \_\_\_\_\_

12. Name William G. Seward

13. Birthplace Not known  
(City, town, or county) (State or foreign country)

14. Maiden name Janet Ann Horn

15. Birthplace Not known  
(City, town, or county) (State or foreign country)

16. (a) Informant Ed. Angell

(b) Address Rockport, Mo.

17. (a) Funeral (b) Date thereof Sept 24, 41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cem.

18. (a) Signature of funeral director J. Parkers

(b) Address Columbia, Mo.

19. (a) 9/24/41 (b) Alvie Selby  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 22  
year 1941 hour 5<sup>PM</sup> minute 30<sup>PM</sup>

21. I hereby certify that I attended the deceased from June 13, 1939 to Sept 22, 1941  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Duress

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 1628  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)

While at work? \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature W. E. Angell (M. D. or other) \_\_\_\_\_  
Address Rockport, Mo.

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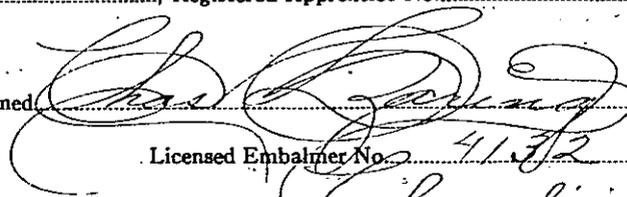
**STATEMENT BY LICENSED EMBALMER**

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. 4132

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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31039

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH: Boone  
 (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: White Convalescent Home  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 yrs  
 In this community 34 yrs (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Louella Angell  
 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 W  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Oct 10 1885  
 (Month) (Day) (Year)

8. AGE: Years 86 Months 11 Days 12 (If less than one day) \_\_\_\_\_ 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 11/12/41 (b) Allie Selby  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day 9 Year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

1941

S-31039