No
-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 12 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34294

Registration District No. 73 Primary Registration District No. 3006 Registrar's No. 291

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

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia City
(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~~ ~~10-10-41 to 10-28-41~~ (Specify whether
In this community 13 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Francois 94

(c) City or town Cantwell 0
(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.? 1 years.

3. (a) PRINT FULL NAME Postlewait John

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male ()

5. Color or race W

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

6. (b) Name of husband or wife Edith

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

7. Birth date of deceased July 21 (Month) 20 (Day) 1894 (Year)

8. AGE:	Years	Months	Days	If less than one day
L	47	43	8	hr. min.

9. Birthplace Washington Co (City, town, or county) O Mo (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Laborer

FATHER
12. Name Dave Postlewait
13. Birthplace Wash Co (City, town, or county) O Mo (State or foreign country)

MOTHER
14. Maiden name Hate Harris
15. Birthplace Wash Co (City, town, or county) O Mo (State or foreign country)

16. (a) Informant Hosp Rec.
(b) Address Garth & Hi 40 Col Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-41 (Month) (Day) (Year)
(c) Place: burial or cremation Cantwell Mo

18. (a) Signature of funeral director C. J. Baxter
(b) Address Desloge Mo

19. (a) 10/28/41 (Date received local registrar) (b) Allie Selby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28 year 1941 hour 6 minute 19 a M.

21. I hereby certify that I attended the deceased from Oct 15 1941, 19 , to Oct 28, 1941; that I last saw him alive on Oct 27, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemorrhage from oesophageal varices	?
Due to Biliary Cirrhosis of liver	?
Due to Biliary calculi	?
Other conditions (Include pregnancy within 3 months of death)	

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Major findings:
Of operations No op.
Of autopsy Biliary Stones c̄ cirrhosis & oesophageal varices

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

23. Signature Gene B. Harklaff (M. D. or other)
Address Hate Cancer Hosp Date signed

(Licensed Embalmer's Statement on Reverse Side)

JAN 2 1942

APR 23 1953

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 [illegible]

Licensed Embalmer No. 3893

P. O. Address Columbia [illegible]

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

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

U. S. No. 2B
10M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34294

Registration District No. 73 Primary Registration District No. 2006 Registrar's No.

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

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

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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: John Postlewait
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife: Edith Postlewait
6. (c) Age of husband or wife if alive: 35 years
7. Birth date of deceased: July (Month) 20 (Day) 1894 (Year)

8. AGE: Years 47 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or country) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 12/22/41 (Date received local registrar) (b) Allie Selby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 28 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Includes pregnancy within 3 months of death)	

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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

JAN 2 1962