

No. 2
1-4-41
-17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37762

State File No. _____

FILLED DEC 8 1941

Registration District No. _____

Primary Registration District No. 3006

Registrar's No. 321

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

3. (a) PRINT FULL NAME Ida Kinsman

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 1 M

6. (b) Name of husband or wife Charles 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased 3 (Month) 27 (Day) 1883 (Year)

8. AGE: Years 58 Months 8 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Lake City Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Louise Clow

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

14. Maiden name Clara Thompson

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

16. (a) Informant Mrs. Claud Parker

(b) Address Bohruville Iowa

17. (a) Removal (b) Date thereof Nov 30 41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake City Iowa

18. (a) Signature of funeral director R. W. [unclear]

(b) Address Columbia Mo

19. (a) 12/1/41 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Taney
(c) City or town Hollister
(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 11 day 29
year 1941 hour 6 minute 45 P M.

21. I hereby certify that I attended the deceased from 9-27-41
_____ 19, to 11-29-41 19;
that I last saw h. PI alive on 11-29-41 19;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Carcinoma Breast 3 yrot
Due to Metastases to Liver and Lungs

Due to Empyema Rt. Lung

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

Major findings: _____
Of operations _____

Of autopsy Carcinoma Breast

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 J. V. Ackerman (M. D. or other) M.D.
Address Ellis Fischel Cancer Hospital Date signed 11/30/41

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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, only.....

.....; Registered Apprentice No.....
working under my personal supervision.

Signed Leonard H. Spina
Licensed Embalmer No. 4613
P. O. Address Columbia, Md

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.