

No. 2  
-13-40  
17-39  
X23159

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

37768

State File No. \_\_\_\_\_

FILLED DEC 8 1943  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3006

Registrar's No. 308

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

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia City  
(c) Name of hospital or institution: University Hosp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 14 wks 3 days  
(Specify whether \_\_\_\_\_)  
In this community 35 yrs  
years, months or days)

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. 207 Thilly Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 16  
year 1941 hour 9 minute 50 P.M.

21. I hereby certify that I attended the deceased from 8/7, 1941, to 11/16, 1941,  
that I last saw him alive on 11/15, 1941,  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cancer of prostate

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

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

Other conditions (Include pregnancy within 3 months of death) 518

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

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

Duration

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? 0

While at work: \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. T. Kuhl (M. D. or other) W. T.

Address Columbia, Mo Date signed 11/17/41

3. (a) PRINT FULL NAME Selwidge, Rolt Washington

3. (b) If veteran, name war Sp Amer 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, ~~widowed~~, married Married

6. (b) Name of husband or wife Selwidge 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased Aug 11 1873(?)  
(Month) (Day) (Year)

8. AGE: Years 68 Months 3 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Mt Vernon, Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Teacher in Univ

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

12. Name James Sewall Selwidge

13. Birthplace Don't know  
(City, town, or county) (State or foreign country)

14. Maiden name Susannah Jane Kirby

15. Birthplace Don't know  
(City, town, or county) (State or foreign country)

16. (a) Informant Harley Selwidge, Bro

(b) Address Sherman Hotel Kansas City Mo

17. (a) Burial (b) Date thereof 11-18-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Am

18. (a) Signature of funeral director Parker's

(b) Address Columbia, Mo

19. (a) 11/17/41 (b) Allie Selby  
(Date received local registrar) (Registrar's signature)

1903 & 1904

**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 Tom M. Hertz

Licensed Embalmer No. 14067

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.