

No. 2
1-4-41
-17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5850

State File No. _____

FILED MAR 19 1942
Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 35

1. PLACE OF DEATH:
(a) County: Boone
(b) City or town: Columbia
(c) Name of hospital or institution: 1006 Wilkes Blvd
(d) Length of stay: In hospital or institution: No
In this community: 43 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Boone
(c) City or town: Columbia
(d) Street No.: 1006 Wilkes Blvd
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME: J. WALTER CARRIER
3. (b) If veteran, name war: None
3. (c) Social Security No.: None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 7 day 9 year 1942 hour 7 minute 30 P.M.
21. I hereby certify that I attended the deceased from 1942 to Jan 7 1942

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Alice Johnson
6. (c) Age of husband or wife if alive: Unknown years
7. Birth date of deceased: Dec 30, 1854

that I last saw him alive on 7-27-42 and that death occurred on the date and hour stated above.
Immediate cause of death: Broncho-pneumonia
Duration: _____

8. AGE: 87 Years 1 Month 9 Days

Due to: Chronic Bronchitis

9. Birthplace: Ontario, Canada

Due to: 107

10. Usual occupation: Physician

Other conditions: Prostatic Hypertrophy

11. Industry or business: _____

Major findings: Prostatic Hypertrophy

12. Name: William Carrier

13. Birthplace: England

14. Maiden name: _____

15. Birthplace: Unknown

Of autopsy: _____

16. (a) Informant: Mrs. Carl Carrier

(b) Address: Des Moines, Ia.

17. (a) Burial, cremation, or removal: Burial (b) Date thereof: Dec 11, 42

(c) Place: burial or cremation: Columbia Cem

18. (a) Signature of funeral director: _____

(b) Address: Columbia, Mo.

19. (a) Date received local registrar: 2/11/42 (b) Registrar's signature: Allie Selby

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? _____
(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: H. M. Chure (M. D. or other)
Address: 805 Broadway Date signed: 7-4-42

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

10
2
4

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

Washing

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 *Charles J. ...*

Licensed Embalmer No. *4182*

P. O. Address *Columbia, Pa.*

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.