

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 Trichel State Cancer Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau

(c) City or town Winters, Mo
(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: 1

3. (a) PRINT FULL NAME Low Davenport

3. (b) If veteran, name war: -

3. (c) Social Security No. -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9th
year 1942 hour 3 minute 10 P.M.

21. I hereby certify that I attended the deceased from

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

6. (b) Name of husband or wife B.F. 6. (c) Age of husband or wife if alive, years 26 1894 (Year)

7. Birth date of deceased: August 26 (Month) (Day) (Year)

that I last saw h. c alive on

and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of Rectum Duration 12 M.

8. AGE:	Years	Months	Days	If less than one day
<u>48</u>	<u>1</u>	<u>11</u>	<u>1</u>	hr. min.

Due to

Due to 468

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

10. Usual occupation housewife

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

MOTHER FATHER { 12. Name John Green

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

14. Maiden name Rachel Bess

15. Birthplace Fredericktown, Mo
(City, town, or county) (State or foreign country)

Major findings: Of operations Carcinoma of Rectum

Of autopsy Pneumonia

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

16. (a) Informant Hospital Record

(b) Address Columbia, Mo

17. (a) Burial (b) Date thereof Oct 9th 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cape Girardeau Mo

18. (a) Signature of funeral director P. W. Green

(b) Address Columbia Mo

19. (a) 10-8-1942 (b) Columbia Mo
(Date received local registrar) (City, town, or county)

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 0

23. Signature J. V. Ackerman M.D. (M. D. or other) M.D.

Address Cancer Hospital Date signed 10/7/42

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

10
2
4

1250

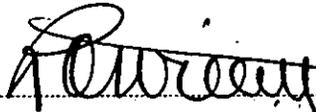
STATEMENT BY LICENSED EMBALMER

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. 31833

P. O. Address Columbia 440

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.