

No. 2
5-42
173

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27668**

FILED SEP 9 1943

Registration District No. _____

Primary Registration District No. **13006**

Registrar's No. **701**

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:
115 E. WORLEY
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **1 MONTH** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cooper**
(c) City or town **Boonville**
(If outside city or town limits, write "RURAL")
(d) Street No. **829 Morgan St.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MRS LUCY WRIGHT**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced, **Widowed**

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

7. Birth date of deceased **MARCH 10 - 1868**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 5 18 hr. min.

9. Birthplace **Cooper County Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **AARON HENDERSON**

13. Birthplace **Cooper County Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **UNKNOWN**

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

16. (a) Informant **Mrs AL Ridgeway**

(b) Address **Columbia, Mo.**

17. (a) **Removal** (Burial, cremation, or removal) (b) Date thereof **8/28/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Boonville Mo.**

18. (a) Signature of funeral director **Stegner-Koenig**

(b) Address **Boonville, Mo.**

19. (a) **Aug 28 - 43** (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **28th**
year **1943** hour **7:15** minute **A.M.**

21. I hereby certify that I attended the deceased from **8/21/43** 19____ to **8/28/43** 19____
that I last saw him alive on **8/27/43** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Asetic Regurgitation
Due to _____

Due to **Toxemia**
Other conditions (Include pregnancy within 3 months of death) **920**

Major findings: Of operations **none**
Of autopsy **none**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **A. Sprague** (M.D. or other) _____
Address **500 Park, Columbia** Date signed **8/28/43**

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

MOTHER FATHER

SEP 28 1943

No. 31
-2-
1943

E R Casteel
1505 Ross
ST

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: *James W. Stigner*

Licensed Embalmer No. *3780*

P. O. Address: *Boonville, M*

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.

Registration District No. 34

Primary Registration District No. 3006

Registrar's No. 206

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 _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME

Lucy Wright

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race B

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Mar 10 1881
(Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) mo.

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 county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9/2 '43 (b) _____ (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 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 (Include 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? _____

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

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

FILED

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