. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27191

Registration District No. 38 Primary Registration District No. 3606-5120 Registrar's No. 217

10
2
4

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: No 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone 10 9
(c) City or town Columbia 4
(If outside city or town limits, write "RURAL")
(d) Street No. 706 Lyons St
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Ora May Eubank
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed 2
6. (b) Name of husband or wife L. B. Eubank
6. (c) Age of husband or wife if alive dead years
7. Birth date of deceased May (Month) 15th (Day) 1869 (Year)

8. AGE: Years 75 Months 3 Days 15 If less than one day ..... hr. ..... min.

9. Birthplace Boone Co (City, town, or county) Mo (State or foreign country) 0
10. Usual occupation House Wife
11. Industry or business
FATHER
12. Name George W. Norse
13. Birthplace D.K (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name Sara Bell Watts
15. Birthplace D.K (City, town, or county) 9 (State or foreign country)
16. (a) Informant Richard Eubank
(b) Address Columbia Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1-1944 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park
18. (a) Signature of funeral director R. Owen
(b) Address Columbia Mo
19. (a) 8-31-44 (Date received local registrar) (b) Edna H. Barbee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30th year 1944 hour 2:30 minute P M.
21. I hereby certify that I attended the deceased from 7-28, 1944 to 8/30, 1944 that I last saw her alive on 8-30-44, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Hypertension
Due to
Other conditions (Include pregnancy within 3 months of death)
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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature F. B. Williamson M.D. or other
Address Columbia Mo Date signed 8/31/44

1250 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9

District File Number.....

Date Filed 9-13-44

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. 3193

P. O. Address.....

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.