

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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

FILED SEP 14 1944

Registration District No. 3006

Primary Registration District No. 3006

Registrar's No. 208

10  
2  
4  
10 years  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(c) Name of hospital or institution: no  
(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 Mo (b) County Boone  
(c) City or town Columbia  
(d) Street No. 815 Sanderfer  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James W Mahan

3. (b) If veteran, name war x 3. (c) Social Security No. R

4. Sex m 5. Color or Race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife Mannie Street 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 3 1864  
(Month) (Day) (Year)

8. AGE: Years 80 Months 2 Days 20 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Farmer

11. Industry or business "

12. Name James T Mahan

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

14. Maiden name Susan Schooley  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs Day alone

(b) Address R.T Columbia

17. (a) Burial (b) Date thereof Aug 26 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cem

18. (a) Signature of funeral director R. J. ...

(b) Address \_\_\_\_\_

19. (a) 8-26-1944 (b) Carroll R. ...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 23 year 1944 hour 6:15 minute P M.

21. I hereby certify that I attended the deceased from Jan 3 to Aug 23 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary block Duration few hrs.

Due to Abnormal Astoria

Due to Age 94

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: None Of operations \_\_\_\_\_

Of autopsy None

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) No

(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? No

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

23. Signature Carroll R. ... (M. D. or other)

Date signed 8-26-44

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 *A. O'Brien*

Licensed Embalmer No. 5183

P. O. Address Columbia

**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.**