

S. No. 2  
M-8-43  
5-17-39  
X37823

DEPARTMENT OF THE COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27215

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

FILED SEP 14 1944

Primary Registration District No. 3006

Registrar's No. 218

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: Boone County Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 1/2 hours  
(Specify whether years, months or days)

In this community 14 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

(c) City or town Columbia  
(If outside city or town limits, write "RURAL")

(d) Street No. Alumas Apts.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Charles Benjamin Paullus

3. (b) If veteran, name war none

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Aug day 31  
year 1944 hour 11 minute 30 A.M.

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

6. (b) Name of husband or wife Mollie Hollinger Paullus 6. (c) Age of husband or wife if alive 6 years

7. Birth date of deceased: 12 - 6 - 1888  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 30, 1944 to Aug 31, 1944  
that I last saw him alive on Aug 31, 1944  
and that death occurred on the date and hour stated above.

8. AGE: Years 55 Months 7 Days 25  
If less than one day .hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death posterior Coronary thrombosis  
Due to Arterio-sclerosis

9. Birthplace Coldwater Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation merchant

Other conditions gfd  
(Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 12. Name James C. Paullus

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

14. Maiden name Dolly Black

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

Major findings: Of operations \_\_\_\_\_

Of autopsy posterior Coronary thrombosis

16. (a) Informant Mrs. C. B. Paullus

(b) Address Alumas Apts, Columbia, Mo.

17. (a) Burial (b) Date thereof 9-2-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

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? \_\_\_\_\_

18. (a) Signature of funeral director Parker Funeral Service

(b) Address Columbia, Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

(c) Means of injury 0

23. Signature E. D. Baskett (M. D. or other) M.D.  
Address Columbia, Mo. Date signed 9/1/44

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

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 M. S. Mitsides

Licensed Embalmer No. 3893

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

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 Boone Co. Hosp  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 1/2 hr.  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles B. Paulus

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

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

7. Birth date of deceased 12 (Month) 12 (Day) 1900 (Year)

8. AGE: Years 55 Months 7 Days 10 If less than one day, \_\_\_\_\_ min.

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

10. Usual occupation Steward

11. Industry or business \_\_\_\_\_

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)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

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

19. (a) 9-2-1944 (b) Edna H. Barber  
(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 Day 1 Year 1944 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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

27215