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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 14 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 209

Registration District No. 38 Primary Registration District No. 3006

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

1. PLACE OF DEATH: Boone
 (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 Convalescent Home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution X (Specify whether
 In this community 19 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Boone ¹⁰
 (c) City or town Columbia ⁹
 (If outside city or town limits, write "RURAL") ⁴
 (d) Street No. North 8th St. (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Martha Ellen Tuggle
 (b) If veteran, name war X
 (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Aug day 24th
 year 1944 hour 6 minute 17 M.

4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, divorced W
 (b) Name of husband or wife James H Tuggle
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb 28 1854
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 30 1944 to Aug 24 1944
 that I last saw her alive on Aug 18 1944
 and that death occurred on the date and hour stated above.

8. AGE: Years 90 Months 5 Days 26 If less than one day hr. min.

Immediate cause of death Septicemia Duration 5 days
 Due to Fracture hip ^{3 wks}

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

Due to General Atherosclerosis ^{15 yrs}

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business "
 12. Name George Amick
 13. Birthplace Ky
 (City, town, or county) (State or foreign country)
 14. Maiden name Nancy Bohltz
 15. Birthplace Ky
 (City, town, or county) (State or foreign country)

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs L D Windsor
 (b) Address N 8th St

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) 118
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)

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

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓

(c) Place: burial or cremation Rose Hill Cem-Howard Co

18. (a) Signature of funeral director P. Overlett
 (b) Address Columbia Mo

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

19. (a) 8-26-1944 (Date received local registrar) (b) Edna H. Barber (Registrar's signature)

23. Signature Stephen D Smith M.D. (M. D. or other)
 Address Columbia Date signed Aug 25

1230 (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 *R. W. Kelley*

Licensed Embalmer No. 3183

P. O. Address *Columbi*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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
(c) Name of hospital or institution: Conv. Home
(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 Martha E. Suggs

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Feb. 28 1904
(Month) (Day) (Year)

8. AGE: Years 90 Months 5 Days 10 If less than one day _____ min.

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

10. Usual occupation Eng.

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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (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 Day 24 Year 1944 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death: Septicemia

Due to: fracture hip

Due to: bad care

Due to: medical error

Other conditions: general arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings: 186a

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) fall in room

(b) Date of occurrence July 30

(c) Where did injury occur? fracture (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? home

While at work? no (Specify type of place) (e) Means of injury just fell

23. Signature Stephen D Smith (M. D. or other)

Address _____ Date signed _____

Duration 5 da

84k

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE PERMANENT RECORD

SUPPLEMENTAL INFORMATION REQUESTED

27229