

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5511

State File No.

FILED MAR 3 1945
Registration District No. 398

Primary Registration District No. 3006

Registrar's No. 1

1. PLACE OF DEATH:

(a) County BOONE
(b) City or town COLUMBIA MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: PRIVATE HOME
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution XX (Specify whether
In this community & 7 Years years, months or days)

3. (a) PRINT FULL NAME GENE M. AFFLICK

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

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced W 2
6. (b) Name of husband or wife THOMAS O AFFLICK
6. (c) Age of husband or wife if alive DEAD years
7. Birth date of deceased MAY 24th 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 7 7 hr. min.

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

10. Usual occupation WIFE
HOUSEKEEPER

11. Industry or business THOS ARMSTRONG

12. Name THOS ARMSTRONG
13. Birthplace CANADA
(City, town, or county) (State or foreign country)
14. Maiden name GENE MAITLAND
15. Birthplace CANADA
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Afflick
(b) Address 11 Hitt
17. (a) Burial (b) Date thereof Jan 3rd 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation II Cem. Shelby
18. (a) Signature of funeral director R. D. Willett
(b) Address Columbia Missouri

19. (a) 1-2-45 (b) Edna H. Barber
(Date received local registrar) (Registrar's signature)

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. 111 HITT
(If rural, give location)
(e) Citizen of foreign country? XX (Yes or No)
If yes, name country XX

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 1st
year 1945 hour 3:45 minute A. M.

21. I hereby certify that I attended the deceased from April 1944 to Jan 1945
that I last saw him alive on Dec 31 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion
Cardiac Arrest
Due to Myocardial Infarction
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 95C
Of autopsy 1

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 R. D. Willett (M. D. or other) DO
Address Columbia Date signed 1/1/45

(Licensed Embalmer's Statement on Reverse Side)

1250

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

RECEIVED

District Health Officer No. 9,

District File No. _____

Date Filed 3-9-45

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 _____

working under my personal supervision.

Signed _____

_____, Registered Apprentice No. _____

_____, Licensed Embalmer No. 3183

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.