S. No. 2
DM—2-43
v. 5-17-39
Z I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 13 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 9004

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 75

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: ELLIS FISCHEL STATE CANCER HOSP (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: JACKSON
(c) City or town: INDEPENDENCE (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: RAYMOND FLOYD MICHAEL
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: BESSIE MICHAEL
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: 9 (Month) 12 (Day) 1907 (Year)

8. AGE: Years 37 Months 6 Days 11 If less than one day hr. min.

9. Birthplace: SKIDMORE (City, town, or county) KANS (State or foreign country)
10. Usual occupation: LABORER
11. Industry or business
FATHER 12. Name: CHARLES MICHAEL
FATHER 13. Birthplace: ILLINOIS (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: NELLIE MICHAEL
MOTHER 15. Birthplace: MISSOURI (City, town, or county) (State or foreign country)
16. (a) Informant: CHARLES MICHAEL
(b) Address: Independence, Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-24-45 (Month) (Day) (Year)
(c) Place: burial or cremation Independence Mo
18. (a) Signature of funeral director: Geo. C. Coulson
(b) Address: Independence Mo
19. (a) 3-24-1945 (Date received local registrar) (b) Edna H. Barlow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 24 year 1945 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from 3-5, 1945, to 3-24, 1945, that I last saw him alive on 3-23, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	3 or 4 days
Due to	
Due to	
Other conditions: None (Include pregnancy within 3 months of death)	

Major findings:
Of operations: Nothing of note.
Of autopsy: See above

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: Lawson V. Ackerman (M. D. or other) M.D.
Address: Cancer Hospital, Columbia Mo Date signed 3/24/45

1260 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9

District File Number.....

Date Filed 4-12-45

APR 17 1945

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 Geo. C. Carson

Licensed Embalmer No. 2249

P. O. Address Independence

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.