No. 2
5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 21 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19836

Registration District No. 38 — Primary Registration District No. 3006 — Registrar's No. 168

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 0 (Specify whether
In this community 26 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Polk 84
(c) City or town Humansville (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no 1 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Rousseau, Nellie
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frank Rousseau
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased January (Month) 12 (Day) 1889 (Year)

8. AGE: Years 56 Months 5 Days 1 If less than one day ..... hr. ..... min.

9. Birthplace Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Geo. Squires
13. Birthplace unknown (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Martha Squires
15. Birthplace S. Carolina (City, town, or county) (State or foreign country)
16. (a) Informant Frank Rousseau
(b) Address Humansville, Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof June 13, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Humansville, Mo
18. (a) Signature of funeral director [illegible]
(b) Address Humansville, Mo
19. (a) 6-13-45 (Date received local registrar) (b) Edna [illegible] Barber (Registrar's [illegible])

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13 year 1945 hour 1 minute 55 P.M.
21. I hereby certify that I attended the deceased from 5-18, 1945 to 6-13-, 1945 that I last saw h. lr alive on ....., 19....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac Failure	1 day
Due to [illegible]	[illegible]
Due to	
Other conditions (Include pregnancy within 3 months of death): Post Radiation Effect Large Bowel	

Major findings:
Of operations none
Of autopsy none

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 R. J. Wedcott (M. D. or other)
Address Cancer Hosp. Date signed 6-13-45

1250

(Lice[illegible]ner's S[illegible]ent on Reverse Side)

JUN 22 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 no embalming, Registered Apprentice No. ..... working under my personal supervision.

Signed E H Primm

Licensed Embalmer No. 4282

P. O. Address Humansville, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 1681

SUPPLEMENTARY

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:
(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)

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

3. (a) PRINT FULL NAME Rousseau, Nellie

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 Jan (Month) 12 (Day) 1889 (Year)

8. AGE: Years 56 Months 5 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from 5-18, 1945 to 6-13, 1945; that I last saw her alive on 6-13, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease c̄ enlargement of heart to left, decompensation

Due to Pulmonary congestion and auricular fibrillation

Due to

Other conditions ca of Cervix - post Radiation treatments
(Include pregnancy within 3 months of death)

Major findings:
Of operations None 48a

Of autopsy none granted

Duration

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 R. J. Westcott (M.D. or other)

Address Date signed

JUL 28 1945

S-19836