No. 2
-11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

23419

State File No.

FILED JUL 31 1945

Registration District No. Primary Registration District No. 3006 Registrar's No. 180

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia R. F. D. #2
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Columbia
(If not in hospital or institution, write street number or location)

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

In this community all her Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Boone

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

(d) Street No. R. F. D. #2.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Anna Bell Claybon

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 3

5. Color or race Colored

6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased 6. (Month) 14 (Day) 1876 (Year)

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

9. Birthplace Callaway Co (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Geo Tucker
13. Birthplace Do not Know (City, town, or county) 0 (State or foreign country)

MOTHER
14. Maiden name Fanny Berry
15. Birthplace Do Not Know (City, town, or county) 0 (State or foreign country)

16. (a) Informant Ruby Claybon
(b) Address R. F. D. #2 Columbia Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6. 18. 45 (Month) (Day) (Year)
(c) Place: burial or cremation Simpson Chapel Stephens Mo

18. (a) Signature of funeral director R. Le Fever
(b) Address 605 Park Ave Columbia Mo

19. (a) 6-19-1945 (Date received by local registrar) (b) Edna H. Barber (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6. day 16 year 45 hour 10 minute 26 M.

21. I hereby certify that I attended the deceased from 5-4, 1945, to 6-16, 1945, that I last saw him alive on 6-14, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis 42 Two.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations None

Of autopsy None

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 W. P. Dyson M.D. (M. D. or other)

Address Callaway Mo Date signed 6-19-45

1220 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 7-16-45

JUL 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 me

, Registered Apprentice No.

working under my personal supervision.

Signed A. C. Freeman

Licensed Embalmer No. 2837

P. O. Address 608 Park Ave. 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, above space should be left blank.

S. 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. Aug

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 9

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Rural Columbia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rup
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

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 Annie B. Clayborn

3. (b) If veteran, name war .....

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

4. Sex F

5. Color or race B

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... if dead .....

7. Birth date of deceased June (Month) 14 (Day) 1878 (Year)

8. AGE: Years 69 Months ..... 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 ..... Day January 16 year 1945 hour ..... minute ..... M.

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

Immediate cause of death Pulmonary Tuberculosis 40 yrs

Due to .....

Due to .....

Other conditions ..... (Include pregnancy within 3 months of death) ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings:
Of operations .....
Of autopsy .....

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 W. B. Nyport (M. D. or other) M. D.

Address ..... Date signed .....

SUPPLEMENTARY

23419