V. S. No. 2
50M—9-4-41
Rev. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED SEP 12 1945

26981

State File No.

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 273

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

4
1
2

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: Stat Hosp #1 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4-30-36 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Boone 14

(c) City or town Columbia 1
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Leona Regel

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife not given

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

7. Birth date of deceased not given (Month) (Day) (Year)

8. AGE: Years 57? Months Days If less than one day hr. min.

9. Birthplace MO 0
(City, town, or county) (State or foreign country)

10. Usual occupation DK

11. Industry or business

FATHER
12. Name not given
13. Birthplace " " 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name not given
15. Birthplace " " 9
(City, town, or county) (State or foreign country)

16. (a) Informant Records
(b) Address Columbia Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-45 (Month) (Day) (Year)
(c) Place: burial or cremation Columbia

18. (a) Signature of funeral director R. Ramillet
(b) Address Columbia Mo

19. (a) Aug 30-1945 (Date received local registrar) (b) Josie Morsinkhoff (Registrar's signature)

11 41

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Aug day 30 year 1945 hour 1 minute 40 P M.

21. I hereby certify that I attended the deceased from 4-30- 1936 to 8-30- 1945 that I last saw h— alive on 8-30- 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death chronic myocarditis central arteriosclerosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 K. E. Shannell (M. D. or other)

Address Fulton MO Date signed 8/30/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 9-11-45

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 ....., Registered Apprentice No. ....., working under my personal supervision.

Signed R O Mullett

Licensed Embalmer No. 3183

P. O. Address Columbia Mo

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.