

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36523

FILED NOV 30 1945

Registration District No.

Primary Registration District No. 3002

Registrar's No. 130

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Centralia, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Centralia Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 70-5-14  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME JOHN McCARGO ANGELL

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 Married  
6. (b) Name of husband or wife Grace E. Angell 6. (c) Age of husband or wife if alive 52 years  
7. Birth date of deceased May 2 1875  
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 14 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business

12. Name James M. Angell  
13. Birthplace Boone Co. Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Grace E. Angell  
15. Birthplace Boone Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. M. Angell  
(b) Address Centralia, Mo.

17. (a) Burial (b) Date thereof 10/17-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Mo., Cen.

18. (a) Signature of funeral director M. McDonald  
(b) Address Centralia, Mo.

19. (a) 10/17-1945 (b) Blanche Neely  
(Date received legal registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone  
(c) City or town Centralia, Rural  
(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 ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 16  
year 1945 hour 6 minute 10 A.M.

21. I hereby certify that I attended the deceased from Oct. 15  
1945, to Oct. 16, 1945  
that I last saw him alive on Oct. 16, 1945  
and that death occurred on the date and hour stated above.  
Immediate cause of death Typhemia

Due to acute nephritis Duration 3 days

Due to Left ischio-rectal abscess Duration 1 week

Other conditions Obesity  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations 170  
Of autopsy 170

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) (c) Means of injury

23. Signature Consolidated (M.D. or other) M.D.  
Address Centralia, Mo. Date signed 10/16/45

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

RECEIVED

District Health Officer No. 10

District File Number 11-45-1755

Date Filed NOV 27 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

*SM. J. Michael*

Licensed Embalmer No. 4313

P. O. Address

*Central Ave*

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.