

No. 2
-5-43
-17-39
X36671

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

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: Noyes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 Weeks
In this community 72 Years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM ELERY ANGELL
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mary Haines Angell 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 1 - 9 - 1873
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 16 If less than one day hr. _____ min. _____

9. Birthplace Boone County Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Physician

11. Industry or business
12. Name William Fielding Angell
13. Birthplace Boone County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Louella Evans
15. Birthplace Boone County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant William Angell
(b) Address Rocheport, Mo.
17. (a) Burial (b) Date thereof 12-28-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Columbia Cemetery
18. (a) Signature of funeral director Parker Funeral Service
(b) Address Columbia, Mo.
19. (a) 12-28-45 (b) Mrs R E Palmer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Rocheport
(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 Dec. day 25
year 1945 hour 6 minute 45 P.M.
21. I hereby certify that I attended the deceased from 2nd 19 45 to 25 19 45
that I last saw him alive on Dec 24 19 45
and that death occurred on the date and hour stated above.
Immediate cause of death Lympho-haem. Sarcoma
Duration _____

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 552
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?
While at work? _____ Means of injury _____
23. Signature W. H. Palmer (M. D. or other) _____
Address Columbia, Mo. Date signed 12-29-45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 1-11-46

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 Thas L. Davis

Licensed Embalmer No. 41321

P. O. Address Columbia, S.C.

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.