

FILED JUN 7 1946

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 124

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(c) Name of hospital or institution: 112 So. 2nd St. 1  
(d) Length of stay: In hospital or institution about 10 yrs  
In this community about 10 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone  
(c) City or town Columbia  
(d) Street No. 112 So. 2nd St. 4  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME MINERVA GORHAM

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race negro  
6. (b) Name of husband or wife Hollie Gorham 6. (c) Age of husband or wife if alive 61 years  
7. Birth date of deceased 6-7-1890

8. AGE: Years 55 Months 11 Days 20  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Bosonville Mo

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Hollie Bruce  
13. Birthplace unknown  
14. Maiden name unknown  
15. Birthplace \_\_\_\_\_

16. (a) Informant Hollie Gorham

(b) Address Columbia Mo

17. (a) Burial (b) Date thereof 5-24-1946

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Street Parker

(b) Address Columbia Mo

19. (a) 5-26-46 (b) Mrs R. E. Palmer

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 21 day May  
year 1946 hour 6 am minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

that I last saw the deceased alive on 20 May 1946 at \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Due to Hypertension

Due to adiposcity wt 260

Other conditions \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature of B. Williams M. D. or other \_\_\_\_\_

Address Columbia Mo Date signed 5-22-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

PHOTO

RECEIVED  
District Health Officer No. 9,  
District File Number \_\_\_\_\_  
Date Filed 6-5-46

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**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 Stuart P. Porter  
Licensed Embalmer No. 2900  
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.**