

S. No. 2
OM-2-43
v. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22680**

FILED JUL 22 1946
Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **160**

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

024

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia

(c) Name of hospital or institution: Boone County Hospital
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution 2 Days
(If not in hospital or institution, write street number or location)

In this community 76 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

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

(d) Street No. Dumas Apts.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME CYNTHIA BELLE HAGGARD

3. (b) If veteran, name war None

3. (c) Social Security No. No

4. Sex Female / 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased 2 - 13 - 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>4</u>	<u>25</u>	hr. _____ min.

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

10. Usual occupation Teacher

11. Industry or business _____

12. Name Alvin Haggard

13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Crotia Stevinson

15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. P.D. Prather

(b) Address Columbia, Mo.

17. (a) Burial (b) Date thereof 7-11-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cemetery

18. (a) Signature of funeral director Parson Funeral Service
Columbia, Mo.

(b) Address _____

19. (a) 7-10-46 (b) Max R. Palmer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1946 hour 9 minute 15 P.M.

21. I hereby certify that I attended the deceased from April 7, 1946 to July 8, 1946
that I last saw her alive on July 8, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary oedema, acute Duration 3 days

Due to Acute myocardial decompensation 5 days

Due to Chronic myocardial degeneration 3 1/2 mo

Other conditions: Benignity
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy III

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? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Maurice E. Cooper (M. D. or other) MD
Address Columbia, Mo Date signed July 10, 1946

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RECEIVED

District Health Officer No. 9

District File Number

Date Filed 7-18-46

OCT 11 1946

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 *Thomas L. Turner*

Licensed Embalmer No. 41327

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.