

STANDARD CERTIFICATE OF DEATH

State File No. **32704**

Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **255**

1. PLACE OF DEATH:

(a) County **BOONE**

(b) City or town **COLUMBIA**

(c) Name of hospital or institution: **WILHITE CONVALESENT HOME** 4
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution **FIVE MONTHS**
(Specify whether years, months or days)

In this community **FIFTEEN YEARS**
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **BOONE** 10

(c) City or town **COLUMBIA** 2
(If outside city or town limits, write "RURAL")

(d) Street No. **XX** 4
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country **XX**

3. (a) PRINT FULL NAME **MISS ANN Mc LACHLAN**

3. (b) If veteran, name war **XX**

3. (c) Social Security No. **XX**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCTOBER** day **24th**
year **1946** hour **11** minute **P.** M.

4. Sex **F** / 5. Color or race **W**

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

6. (b) Name of husband or wife **SINGLE**

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

21. I hereby certify that I attended the deceased from **10-10-46** to **10-24-46**

that I last saw him ~~or~~ alive on **10-24-46** and that death occurred on the date and hour stated above.

Immediate cause of death **Central Nervous System** Duration **see or 24 days**

8. AGE: Years **90** Months **1** Days **27**
If less than one day hr. min.

Due to **Arterio Sclerosis**

Due to **Old age**

9. Birthplace **BANFFSHIRE** **SCOTLAND** 4
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSE KEEPER**

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business

12. Name **ALEXANDER Mc LACHLAN** 11

13. Birthplace **BANFFSHIRE** **SCOTLAND** 1
(City, town, or county) (State or foreign country)

14. Maiden name **HELEN GRANT**

15. Birthplace **SCOTLAND** 4
(City, town, or county) (State or foreign country)

16. (a) Informant **ROBT L. MCLACHLAN**

(b) Address **HI WA 40- COLUMBIA MO**

17. (a) **BURIAL** (b) Date thereof **OCT. 28-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. PLEASANT-NEW FRANKLIN**

18. (a) Signature of funeral director **K. Palmer**

(b) Address **COLUMBIA MO**

19. (a) **10-26-46** (b) **Mrs. R.E. Palmer**
(Date received local registrar) (Registrar's signature)

Major findings: Of operations **83%**

Of autopsy **None**

PHYSICIAN **None**
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) **No**

(b) Date of occurrence **No**

(c) Where did injury occur? **No**
(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? **No** (e) Means of injury **No**

23. Signature **W.P. Deary** (M. D. or other) **M.D.**

Address **Columbia Mo** Date signed **10-26-46**

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

RECEIVED
District Health Officer No. 9,
District File Number
Pass Filed 10/29/46

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

Signed *Lyman H. Spink*

Licensed Embalmer No. *24013*

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.