

U.S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X36671

FILED NOV 1 1946

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

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 257

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:  
1007 Walnut St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether 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. 1007 Walnut St. 4  
(If rural, give location)

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

3. (a) PRINT FULL NAME ANNA BELLE TODD

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 24  
year 1946 hour 3 minute 30 A.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife George Todd

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

7. Birth date of deceased 3 - 17 - 1867  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 24 1946 to Oct 24 1946  
that I last saw her alive on Oct 24 1946  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

79	7	7	hr. _____ min.
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Immediate cause of death Coronary occlusion

Due to arterio-sclerosis 3 hours

Due to age

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

10. Usual occupation At Home

Other conditions None  
(Include pregnancy within 3 months of death)

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

MOTHER FATHER { 12. Name Robert McClary 4

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

14. Maiden name Mary Ann Cochran /

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

Major findings: 94A

Of operations \_\_\_\_\_

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

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Larry Sapp

(b) Address Columbia, Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 10-25-46  
(Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cemetery

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

(b) Address \_\_\_\_\_

19. (a) 10-26-46 (Data received local registrar)

(b) Mrs. P. E. Palmer (Registrar's signature)

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? \_\_\_\_\_

23. Signature [Signature] (M. D. or other) /  
Address Columbia, Mo. Date signed 10/25/46

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

RECEIVED  
District Health Officer No. 9,  
District File Number.....  
Date 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, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Tom M Harg  
Licensed Embalmer No. 4067  
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.