

No. 2
1-5-43
5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41245

FILED DEC 30 1946

Registration District No. 89

Primary Registration District No. 203-85690

Registrar's No. 230

1. PLACE OF DEATH

(a) County Linn

(b) City or town St. Catharines
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Yellow Creek Township
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 65 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Linn

(c) City or town St. Catharines
(If outside city or town limits, write "RURAL")

(d) Street No. Yellow Creek Twns
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME COLUMBUS AMERICA BLACK

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14
year 1946 hour 9 minute 15 P M.

4. Sex Mo 5. Color or race B

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

6. (b) Name of husband or wife Grace H. Black

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased April 4 - 1881
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10/5/46, 19____, to _____, 19____;

that I last saw him alive on 12-14-46, 19____;

and that death occurred on the date and hour stated above.

8. AGE: Years 65 Months 8 Days 10 If less than one day hr. min.

Immediate cause of death Cerebral thrombosis Duration 3 mo

Due to Arterio Sclerosis Yes

9. Birthplace St. Catharines Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: § 310

Of operations _____

Of autopsy _____

11. Industry or business _____

12. Name Francis Black

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

14. Maiden name Emma Houseman

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Helen Black

(b) Address St. Catharines Mo

17. (a) Burial (b) Date thereof Dec-17-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Bern

18. (a) Signature of funeral director Hill Funeral Home

(b) Address Brookfield Mo

19. (a) 12-17-46 (b) W. B. Erwin
(Date received local registrar) (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? _____

(Specify type of place)

23. Signature John Lucas (M.D. or other) _____

Address Brookfield Mo Date signed 12/14/46

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

MOTHER FATHER

167

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 J. W. Blacklock

Licensed Embalmer No. 2276

P. O. Address. Brookfield 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.

Registration District No. 184

Primary Registration District No. 5690

Registrar's No. 230

1. PLACE OF DEATH:

(a) County Linn
(b) City or town St Catherine
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Yellow Creek Township
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 65 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Columbus A. Black

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Grace H. Black 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased April 4 (Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 20 If less than one day hr. min.

9. Birthplace St Catherine Mo (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER, FATHER { 12. Name Francis Black

13. Birthplace D. K. D. W. (City, town, or county) (State or foreign country)

14. Maiden name Emma Houseman

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

16. (a) Informant Mrs. Grace H. Black

(b) Address St Catherine, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17, 1946 (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemetery

18. (a) Signature of funeral director Hill Funeral Home

(b) Address Brookfield, Mo.

19. (a) 12/17/46 (Date received local registrar) (b) W. H. Egan (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Linn
(c) City or town St Catherine
(If outside city or town limits, write "RURAL")
(d) Street No. Yellow Creek Township
(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 Year 1946 hour 15 minute 15 P.M.

21. I hereby certify that I attended the deceased from 10/10/46 to 12-14-46, 1946; that I last saw him alive on 12-14-46, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 3 mo.
Due to Arterio Sclerosis year year
Due to

Other conditions (Include pregnancy within 3 months of death)

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 Mo. H. Lucas (M. D. or other) M.D.
Address Brookfield, Mo. Date signed 12/19/46

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

23
45
3880

41245