

Registration District No. 36

Primary Registration District No. 5118

State File No. _____

Registrar's No. 18

1. PLACE OF DEATH:

(a) County Boone
(b) City or town McBaine mo Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life years, months or days

3. (a) PRINT FULL NAME Nancy Jane Acton
3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife William Acton 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb 17 1884
(Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Boone Co mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Tom Grant

13. Birthplace Boone Co mo
(City, town, or county) (State or foreign country)

14. Maiden name Ellie Donahoo

15. Birthplace Boone Co mo
(City, town, or county) (State or foreign country)

16. (a) Informant Orin Acton

(b) Address McBaine mo Route

17. (a) Burial (b) Date thereof Jan 27-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cem

18. (a) Signature of funeral director R. W. Reed

(b) Address Columbia mo

19. (a) Jan 30-47 (b) Mrs. H. H. Russell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Boone (b) County Missouri
(c) City or town Columbia Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 10 mi S- McBaine Route
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 25
year 1947 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Unknown
Due to Believed to be heart disease

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 Coroner

23. Signature W. H. Reed Date signed 25/47
Address Columbia Mo

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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. Sprinkle

Licensed Embalmer No. 4013

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.