

Filed **JUN 4 1947**

Registration District No. **38**

Primary Registration District No. **3006**

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 **1602 Hinkson Ave.**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **27 Years** (Specify whether years, months or days)  
 In this community **27 Years**

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. **1602 Hinkson Ave.**  
 (If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No)  
 If yes, name country

10  
2  
4  
0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **25**  
 year **1947** hour **8** minute **P.** M.

21. I hereby certify that I attended the deceased from **May 17**  
 to **May 25**, 19**47**,  
 that I last saw him alive on **May 25**, 19**47**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Intestinal Flu** Duration **9 days**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **None**

Of autopsy **None**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **No**

(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) While at work? (Specify means of injury)

23. Signature **W. D. Deppert** (M. D. or other) **M.D.**  
 Address **College Camp** Date signed **5-26-47**

PHYSICIAN

Underline the cause of which death should be charged statistically.

3. (a) PRINT FULL NAME **SALLIE WILL CARR**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **James T. Carr** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **6 - 5 - 1870**  
 (Month) (Day) (Year)

8. AGE: Years **76** Months **11** Days **20** If less than one day **hr. min.**

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

10. Usual occupation **At Home**

11. Industry or business **John Crews**

12. Name **John Crews** 13. Birthplace **Callaway County Missouri**  
 (City, town, or county) (State or foreign country)

14. Maiden name **Louisa Baker**

15. Birthplace **Callaway County Missouri**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ruth Schreen**

(b) Address **1602 Hinkson Ave., Columbia, Mo.**

17. (a) **Burial** (b) Date thereof **5-27-47**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Millersburg**

18. (a) Signature of funeral director **Parsons Funeral Service**

(b) Address **Columbia, Mo.**

19. (a) **5-28-47** (b) **Mrs R & Palmer**  
 (Date received local registrar) (Registrar's signature)

MOTHER FATHER

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

**RECEIVED**  
District Health Officer No. 9,  
District File Number  
Date Filed JUN 3 1947

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..... *Chas. L. Baum* .....  
Licensed Embalmer No. *4132* .....  
P. O. Address *Columbia* .....

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.