

FILED NOV 18 1947

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 278

1. PLACE OF DEATH:

(a) County Boone Co.
(b) City or town Columbia, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Ellis Fischel State Cancer Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 83 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Putnam **26**
(c) City or town Lucerne **0**
(If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Studabaker, Elizabeth May

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 22, 1870
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	76	10	3	12 hr. 55 min.

9. Birthplace Adams Co., Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business _____

12. Name Abram Studabaker

13. Birthplace Adams County, Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Sarah C. McConkey

15. Birthplace Adams County, Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Elizabeth May Studabaker

(b) Address Lucerne, Missouri

17. (a) Removal (b) Date thereof 10 27 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LUCERNE CEMETERY

18. (a) Signature of funeral director Passino's of Spina

(b) Address Columbia Mo

19. (a) 10-27-47 (b) Mrs R.E. Palmer
(Date received local registrar) (Registrar's signature)

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MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October, day 26
year 1947 hour 12:55 p. minute _____ M.

21. I hereby certify that I attended the deceased from Aug 1, 1947, to 10-26, 1947,
that I last saw her alive on 10-26, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis, acute Duration 1 wk

Due to Adeno Ca of ovary 2 yr.

Due to _____

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

Major findings: Of operations _____

Of autopsy above

PHYSICIAN

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) _____

(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 John O. Schmitt, MD (M. D. or other)

Address Ellis Fischel Hosp. Date signed 10-27-47

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

MOTHER FATHER

DEC 30 1947

RECEIVED
District Health Officer No. 9,
District File Number
NOV 17 1947
Date Filed

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 *M. J. Whitfield*
Licensed Embalmer No. 3893
P. O. Address *Chambers me*

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.