

No. 2
-12-45
5-17-39
K47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 29 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44142**
Registrar's No. **18**

Registration District No. **38**

Primary Registration District No. **3006**

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

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:
Boone Co. Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 da**
In this community **life**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Boone 10**
(c) City or town **Centralia**
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No!)
If yes, name country _____

3. (a) PRINT FULL NAME **INA-K-NORTHCUTT**
3. (b) If veteran, name war **L**
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **13**
year **47** hour **3** minute **P.M.**
21. I hereby certify that I attended the deceased from **Oct. 4** 19**47** to **Dec. 10** 19**47**
and that I last saw her alive on **Dec. 10** 19**47**
and that death occurred on the date and hour stated above.

4. Sex **F** 5. Color or race **W.**
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 **Feb. 20 1877**
(Month) (Day) (Year)

Immediate cause of death **Coronary thrombosis** Duration **3 mon**
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

8. AGE: Years **70** Months **9** Days **5**
If less than one day hr. _____ min. _____
9. Birthplace **Andrain Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name **William Northcutt**
13. Birthplace **KY**
(City, town, or county) (State or foreign country)
14. Maiden name **KEZIAH Beardman**
15. Birthplace **KY**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.
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MOTHER FATHER
16. (a) Informant **Mrs. W. T. Northcutt**
(b) Address **Centralia Mo.**
17. (a) **Burial** (b) Date thereof **Dec-15-47**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Centralia, Mo.**
18. (a) Signature of funeral director **Howe Jensen**
(b) Address **Centralia Mo.**
19. (a) **1-19-48** (b) **Mrs R.E. Palmer**
(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) (c) Means of injury _____
23. Signature **L. Lachance** (M. D. or other) **M.D.**
Address **Centralia, Mo.** Date signed **1-16-48**

APR 1 1948

Date Filed JAN 28 1948

District File Number

District Health Officer No. 9

RECEIVED

JAN 29 1948

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 *George Jernigan*

Licensed Embalmer No. 4270

P. O. Address *Central Ave*

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.