

FILED FEB 24 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 4025BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 53

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>  |  |
| c. LENGTH OF STAY (in this place) <u>49 Years</u>  |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>405 Matthews St.</u>                             |  | d. STREET ADDRESS (If rural, give location) <u>405 Matthews St.</u>   |  |

|                                     |                              |                            |           |   |
|-------------------------------------|------------------------------|----------------------------|-----------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>JAMES PEEK</u> | b. (Middle) <u>ROYSTON</u> | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Feb. 17, 1949</u> |
|-------------------------------------|------------------------------|----------------------------|-----------|---|

|                    |                               |  |                                      |   |                                  |                                  |
|--------------------|-------------------------------|--|--------------------------------------|---|----------------------------------|----------------------------------|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>July 5, 1858</u> | 9. AGE (In years last birthday) <u>90</u> | IF UNDER 1 YEAR<br>Months   Days | IF UNDER 24 HRS.<br>Hours   Min. |
|--------------------|-------------------------------|--|--------------------------------------|---|----------------------------------|----------------------------------|

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)<br><u>Green County, Tennessee</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u> |
|--|-----------------------------------|---|---|

|   |   |   |
|---|---|---|
| 13a. FATHER'S NAME<br><u>Cyrus Augustus Royston</u> | 13b. MOTHER'S MAIDEN NAME<br><u>Mary Frances Callaway</u> | 14. NAME OF HUSBAND OR WIFE<br><u>Alice Elley Royston</u> |
|---|---|---|

|   |  |  |         |
|---|--|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> | 16. SOCIAL SECURITY NO.<br><u>None</u> | 17. INFORMANT'S SIGNATURE OR NAME<br><u>James Foy Royston, Columbia, Mo.</u> | ADDRESS |
|---|--|--|---------|

|   |   |  |                                  |
|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u>   |  |                                  |
|   | ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Arterio sclerosis</u><br>DUE TO (c) |  |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |   |  |                                  |

|                        |   |  |
|------------------------|---|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION<br><u>1500</u><br><u>etc</u> | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|---|--|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

|  |  |                            |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from Oct 10, 1877, to Feb 17, 1949 that I last saw the deceased alive on Feb 6, 1949 and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

|   |                                      |                                    |
|---|--------------------------------------|------------------------------------|
| 23a. SIGNATURE (Degree or title)<br><u>S. J. Waskett M.D.</u> | 23b. ADDRESS<br><u>Columbia, Mo.</u> | 23c. DATE SIGNED<br><u>2-18-49</u> |
|---|--------------------------------------|------------------------------------|

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 24b. DATE<br><u>Feb. 20, 1949</u> | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Memorial Park Cemetery</u> | 24d. LOCATION (City, town, or county) (State)<br><u>Columbia, Mo.</u> |
|--|-----------------------------------|---|---|

|  |  |  |         |
|--|--|--|---------|
| DATE REC'D BY LOCAL REG.<br><u>Feb 18 1949</u> | REGISTRAR'S SIGNATURE<br><u>Mrs. R E Palmer 31</u> | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Parker Funeral Service, Columbia, Mo.</u> | ADDRESS |
|--|--|--|---------|

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10. 4810  
2  
4

RECEIVED  
District Health Officer No. 9;  
District No. 10000  
Date Filed FEB 23 1949

NOV 12 1949

**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed Charles H. Taring

Signed.....  
Student Embalmer

Licensed Embalmer No. 4132

P. O. Address Columbia, W

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.