

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22520**

FILED AUG 9 1949

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

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>198</u>				
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission). 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. LENGTH OF STAY (In this place) <u>1</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		d. STREET ADDRESS (If rural, give location) <u>1204 Mores Blvd.</u>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1204 Mores Blvd</u>				d. STREET ADDRESS (If rural, give location) <u>1204 Mores Blvd.</u>						
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROSE</u>			b. (Middle) <u>MARY</u>		c. (Last) <u>CHRISTIAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 1, 1949</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 31, 1902</u>		9. AGE (In years last birthday) <u>47</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 1 Wk.: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Boone County, Missouri</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Matthew Barnes</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Alice Pugh</u>			14. NAME OF HUSBAND OR WIFE <u>W.E. Christian Jr.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>W.E. Christian Jr., Columbia, Mo.</u>					ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis & Atherosclerosis</u> <u>Dissecting Aneurysm</u> ANTECEDENT CAUSES: <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Atherosclerosis of Heart & Decompensation</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 mo</u> <u>4 1/2 mo</u> <u>3 mo</u>		
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input 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) _____		21d. (COUNTY) _____		21e. (STATE) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 <u>Jan 1949</u> , to <u>8-1-1949</u> , that I last saw the deceased alive on <u>7-31-1949</u> , and that death occurred at <u>9:45 P.M.</u> , from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) <u>Frank E. DeStefano M.D.</u>				23b. ADDRESS <u>Columbia Mo.</u>			23c. DATE SIGNED <u>8-3-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 4, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Columbia, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>Aug 4 49</u>		REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Parker Funeral Service</u>		ADDRESS <u>Columbia, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
AUG 8 1919
DISTRICT HEALTH OFFICE NO. 9,
District File Number

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.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.