

BIRTH NO. _____ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **39**

1. PLACE OF DEATH a. COUNTY BOONE CO MO		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY BOONE	
b. CITY (If outside corporate limits, write RURAL and give township) BOONE		c. CITY (If outside corporate limits, write RURAL and give township) COLUMBIA 0105	
c. LENGTH OF STAY (In this place) 12 HR		d. STREET ADDRESS (If rural, give location) 506 N 4th St	
d. FULL NAME OF HOSPITAL OR INSTITUTION BOONE CO Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) HOWARD b. (Middle) Logan c. (Last) Logan		4. DATE OF DEATH (Month) (Day) (Year) 2 10 1955	
5. SEX Male	6. COLOR OR RACE 2 Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 1893
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitor		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ASHLAND MO
12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME CHARLIE LOGAN		13b. MOTHER'S MAIDEN NAME Don't Know		14. NAME OF HUSBAND OR WIFE Eda Mae Logan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 486-18-2867		17. INFORMANT'S SIGNATURE OR NAME NAONI JONES	
				ADDRESS 506 N 4th St	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Lung		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH undet.	
ANTECEDENT CAUSES		DUE TO (b)					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 163 X		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		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 **Feb. 9, 1955**, to **Feb. 10, 1955**, that I last saw the deceased alive on **Feb. 9, 1955**, and that death occurred at **7:30 AM**, from the causes and on the date stated above.

23a. SIGNATURE C. E. Jones, M.D.		(Degree or title)		23b. ADDRESS 509 N. Third Columbia, Mo		23c. DATE SIGNED 2-10-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb. 13-55		24c. NAME OF CEMETERY OR CREMATORY 69 Providence		24d. LOCATION (City, town, or county) (State) South of Columbia, Mo	
DATE REC'D BY LOCAL REG. Feb 12 1955		REGISTRAR'S SIGNATURE Mrs R.E. Palmer		3 1-0		25. FUNERAL DIRECTOR'S SIGNATURE Victor Brown	
						ADDRESS 608 Park Ave	

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 A. C. Freeman

Licensed Embalmer No. 2837

P. O. Address Columbia Md

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.