

FILED AUG 19 1957

## STANDARD CERTIFICATE OF DEATH

'57 0 27 4 98  
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 294

1. PLACE OF DEATH a. COUNTY <i>Boone</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Boone</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Columbia</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Columbia</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>9 South 1st St</i>		Length of stay in 1b <i>8 months</i>		d. STREET ADDRESS (If outside, give location) <i>9 South 1st St.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>THAD</i>				4. DATE OF DEATH Month <i>Aug.</i> Day <i>12</i> Year <i>1957</i>				
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Wepo</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 23 - 1878</i>		
9. AGE (In years last birthday) <i>78</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm labor</i>		11. BIRTHPLACE (City and state or country) <i>Boone county Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>Lewis Warren</i>				14. MOTHER'S MAIDEN NAME <i>Maggie Moore</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>486-12-1705</i>		17. INFORMANT Address <i>Maggie Coleman Columbia, Mo.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral embolism</i>							INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Fracture right humerus</i>		DUE TO (c) <i>Trauma</i>		7 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>21</i> <i>Chronic asthma - Generalized arteriosclerosis</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Patient fell due to mis-step at home.</i>						
20c. TIME OF INJURY Hour <i>6:30 p.m.</i> a. m. <i>8-12-57</i> Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. CITY, TOWN, OR LOCATION <i>Columbia</i>		
		20g. COUNTY <i>Boone</i>		20h. STATE <i>Missouri</i>				
21. I attended the deceased from <i>Pathologist</i> and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Lorraine E. Schultz</i>				22b. ADDRESS <i>Boone Co. Hosp. - Columbia, Mo.</i>		22c. DATE SIGNED <i>8-12-57</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>8/15/57</i>		23b. DATE <i>8/15/57</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>		23d. LOCATION (City, town, or county) (State) <i>Columbia Mo-</i>		
24. FUNERAL DIRECTOR <i>Mrs. Stuart Parker, Columbia, Mo.</i>				25. DATE RECD. BY LOCAL REG. <i>Aug 15 1957</i>		26. REGISTRAR'S SIGNATURE <i>Mrs. R.E. Palmer.</i>		

(Licensed Embalmer's Statement on Reverse Side)

300  
1-56Health, Welfare  
Public  
ServiceAll  
No symptoms will be listed. All  
Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Pathologist - as such cannot sign - Dr. Neal - MD - Coroner - Ok -

MEDICAL CERTIFICATION

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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 .....  
Signature of Student Embalmer

Signed *Edward H. Krueger* .....

Licensed Embalmer No. 49

P. O. Address *Columb*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.