

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035164

FILED VS NOV 2 1959 38

Registration District No. _____ Primary Registration District No. 3006 Registrar's No. 527

STATE FILE NUMBER

ENDED

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|--|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Boone | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Boone | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia | | Length of stay in 1b Lifetime | c. CITY OR TOWN Columbia | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Boone County Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1114 Wilkes | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last LINNIE ANN BOHANAN | | | 4. DATE OF DEATH Month Day Year October 30, 1959 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5-28-1885 | 9. AGE (last birthday) 74 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Boone County, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME William Riley Nichols | | 13b. MOTHER'S MAIDEN NAME Elizabeth Walton | | 14. NAME OF HUSBAND OR WIFE James Thomas Bohanan | | |
| 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. None | 17. INFORMANT Address James Cecil Bohanan, Columbia, Mo. | | | |
| 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>Strangulated umbilical hernia, 3 days</i> DUE TO (b) <i>with gangrene of bowel</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Probable myocardial infarction</i> | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input 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.) | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY | STATE | | |
| 21. I attended the deceased from <i>1954</i> to <i>30 Oct 59</i> and last saw her <i>alive</i> on <i>30 Oct 59</i> - Death occurred at <i>8:50 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE <i>LeRoy Miller M.D.</i> (Degree or title) | | | 22b. ADDRESS <i>Guitor Bldg Columbia</i> | | 22c. DATE SIGNED <i>30 Oct 59</i> | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | 23b. DATE <i>11-1-1959</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>New Providence Cemetery</i> | 23d. LOCATION (City, town, or county) (State) <i>Boone County, Missouri</i> | | | |
| 24. FUNERAL DIRECTOR Parker Funeral Service, Columbia, Mo. | | ADDRESS | 25. DATE RECD. BY LOCAL REG. <i>Oct 30, 1959</i> | 26. REGISTRAR'S SIGNATURE <i>Mrs R E Palmer</i> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____ Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Paul L. Fucina

Licensed Embalmer No. 413

P. O. Address Channah

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.