

FEB 15 1937

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Do not use this space.

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1. PLACE OF DEATH

County Boone
Township Columbia
City Columbia (No. 1)

Registration District No. 73
Primary Registration District No. 3006

File No. 9
Registered No. 9
St. Ward

2. FULL NAME

(a) Residence, No. 313 N. 9th St., Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Henry Sander
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-8-1864
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
72 10 29

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co. Missouri
13. NAME Ruben Alspar
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio
15. MAIDEN NAME Eva Olson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa.

17. INFORMANT (ADDRESS) Mr. Homer Crosswhite
Columbia, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Shipping Springs DATE 1-9-37
19. UNDERTAKER (ADDRESS) Huber Furniture Co.
Columbia, Mo.
20. FILED 1/8/37 1937 Albie Selby Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-7-193722. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1936 to Jan 7, 1937

I last saw him alive on Jan 6, 1937 Death is said to have occurred on the date stated above, at 90 m.
The principal cause of death and related causes of importance were as follows:

Cardiac asthma
hypostatic pneumonia
Date of onset

Other contributory causes of importance:

Hypertension
arteriosclerosis
hypertrophy

Name of operation Date of
What test confirmed diagnosis? Cholera Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury , 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Reginald Board M. D.
(Address) Columbia, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1500

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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1. PLACE OF DEATH

County Boone
Township Columbia
City _____ (No. _____)

Registration District No. 73
Primary Registration District No. 3006

File No. _____
Registered No. 9
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 3157 924 St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 10 29

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS)

20. FILED 3/23/37 Allie Selby Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-7 1937

22. I HEREBY CERTIFY, That I attended deceased from

_____ 19_____, to _____ 19_____. I last saw him _____ alive on _____ 19_____. Death is said

to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

nephritis Chronic

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____ 19_____. Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify

(Signed) W. R. Robinett M. D.

(Address) Columbia Mo

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