

REC'D APR 10 1939

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

10011
Do not use this space.

1. PLACE OF DEATH

(a) County Boone Registration District No. 73

(b) Township Columbia Primary Registration District No. 3006 Registered No. 60

(c) City Columbia (d) Street No. Boone County Hospital St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)

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

2. PRINT FULL NAME MATTIE BELLE ZARING

(a) Residence, No. Centralia, Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

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 R. W. Zaring

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 7, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

79 10 1

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Housewife

9. Industry or business in which work was done, as 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) Shelbysville Kentucky

13. NAME John Mount

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

15. MAIDEN NAME Fannie Watson

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

17. INFORMANT (ADDRESS) J. B. Zaring

18. BURIAL, CREMATION, OR REMOVAL PLACE Centralia, Mo. DATE 3-10-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Barker's Columbia, Mo.

20. FILED 3/10/39 Allie Selby Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/4, 1939

22. I HEREBY CERTIFY, That I attended deceased from 3-1-, 1939, to 3-2-, 1939

I last saw h. alive on 3-2-, 1939. Death is said to have occurred on the date stated above, at 1 P.M.

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

Pneumonia Bronchial Date of onset 3-1-39

Other contributory causes of importance: Broken hip

Name of operation None Date of _____

What test confirmed diagnosis? X-ray. Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Accident Date of injury 3-1-, 1939

Where did injury occur? near Boone Co. Mo. (Specify city or town, county, and State)

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

Manner of injury Broken Hip, Fall out

Nature of injury fall

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) W. D. Depoent, M. D.

74 (Address) Columbia, Mo.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

V. S. No. 2
50M-9-13-33
I X18603

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *M N McPhaul*.....

Licensed Embalmer No. *3893*.....

P. O. Address *Columbus*.....

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, above space should be left blank.