

Registration District No. 73

Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Boone County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether

In this community
years, months or days

8. (a) PRINT FULL NAME Willie T. Townsend

8. (b) If veteran, name war: _____ 8. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband Homer Townsend 6. (c) Age of husband 56 years alive _____ years

7. Birth date of deceased: Oct 19 1876
(Month) (Day) (Year)

8. AGE: Years 62 Months 10 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Harrisonville Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER { 12. Name H. R. Bryant

13. Birthplace Versailles Kentucky
(City, town, or county) (State or foreign country)

14. Maiden name Sarah E. Ryan

15. Birthplace Mercer Co. Ky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Homer Townsend

(b) Address 2450 N. 60th St. Milwaukee Wis

17. (a) Burial (b) Date thereof Sept 6 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harrisonville, Mo

18. (a) Signature of funeral director Van McCharg

(b) Address W. Columbus, Mo

19. (a) 9/5/39 (b) Allie Selby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Wisconsin (b) County Milwaukee
(c) City or town Milwaukee
(If outside city or town limits, write "RURAL")
(d) Street No. 2450 N. 60th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 4th day _____ year 1939 hour 4 minute P M.

21. I hereby certify that I attended the deceased from Aug 28, 1939, to Sept 4 1939 that I last saw her alive on Sept 4 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Broncho pneumonia following operation, Gastro-Enterostomy
Due to Arteriosclerotic ulcer

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations Arteriosclerotic ulcer

Of autopsy Same

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature Robert J. Simpson M.D. (M. D. or other) _____
Address Columbia Mo Date signed 9/2/39

WHILE FILLING IN USE UNFADING BLACK INK—MAKE 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.

I 41981

APR 17 1947

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 Me

..... Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No. 40167

P. O. Address Columbia, Mo

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.