

FILED AUG 25 1941

Registration District No. **73**

Primary Registration District No. **3006**

Registrar's No. **195**

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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: **1**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **none**
 In this community **about 50 years**
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME **MAGGIE WASHINGTON**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **Female** **5. Color or race** **negro** **6. (a) Single, widowed, married, divorced** **Single**
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased **about 1891**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	about 50	-	-	hr. min.

9. Birthplace **Columbia** **Mo.**
 (City, town, or county) (State or foreign country)
10. Usual occupation **Domestic**

11. Industry or business _____
MOTHER FATHER
12. Name **William Washington**
13. Birthplace **Don't know**
 (City, town, or county) (State or foreign country)
14. Maiden name **Amelia Banks**
15. Birthplace **Don't know**
 (City, town, or county) (State or foreign country)

16. (a) Informant **George Washington**
(b) Address **Columbia Mo.**
17. (a) Burial **(b) Date thereof** **7-26-1941**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Log Providence Mo.**
18. (a) Signature of funeral director **Walter Parker**
(b) Address **Columbia Missouri**

19. (a) 7/28/41 **(b) Allie Selby**
 (Date received local registrar) (Registrar's signature)
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2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Boone**
 (c) City or town **Columbia**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **109 N. 3rd St**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **23** year **41** hour **9** minute **05 am.**
21. I hereby certify that I attended the deceased from **7-22-41** to **7-23-41**
 that I last saw her alive on **7-20-41** and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
She fell & hurt her head on the 16.
 Due to _____

Due to **not known**
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations **None**
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide, specify: **She fell on 16-**
 (b) Date of occurrence **7-16-41**
 (c) Where did injury occur? **Columbia, Mo.**
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
 (Specify type of place) (e) Means of injury _____

23. Signature **W. P. Ayscough** (M. D. or other) **Mo.**
Address **Columbia Mo.** Date signed _____

Duration
4 days to 1 hr.
PHYSICIAN
 Underline the cause to which death should be charged statistically.

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 _____

Licensed Embalmer No. 7900

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, fact should be so stated above.