

S. No. 2
M-5-42
v. 5-17-39
I X32873

State File No. **36635**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 9 1942

Registration District No. **208**

Primary Registration District No. **3606-5120**

Registrar's No. **259**

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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 **Brown Station - Columbia Township**
(If outside city or town limits, write "RURAL" and name of Township)

(c) Name of hospital or institution: **/**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **82 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone**

(c) City or town **Brown Station**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **LUCY DENNIS**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Frank Dennis**

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **9 - 11 - 1860**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **18** year **1942** hour **4:30** minute **A.** M.

21. I hereby certify that I attended the deceased from **8-3** to **Nov. 18-1942** that I last saw him alive on **Nov. 17-1942** and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
82	2	7	hr. _____ min.

Immediate cause of death **Cerebral hemorrhage** Duration **four days**

Due to **Hardened Arteries**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **No**

9. Birthplace **Boone County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

Major findings: Of operations **No**

Of autopsy **No**

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11. Industry or business _____

MOTHER FATHER { 12. Name **John Schooler**

13. Birthplace **Not Known**
(City, town, or county) (State or foreign country)

14. Maiden name **Not Known**

15. Birthplace **Not Known**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Granville Persinger**

(b) Address **Columbia, Missouri.**

17. (a) **Burial** (b) Date thereof **11-19-42**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Dripping Springs**

22. If death was due to external causes fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence **No**

(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? **No**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **W. P. Stewart** (M. D. or other) **M.D.**
Address **Columbia, Mo.** Date signed **11-18-42**

18. (a) Signature of funeral director **Parkinson Service**

(b) Address **Columbia, Missouri**

19. (a) **11-18-1942** (b) **E. Alna H. Barber**
(Date received local registrar) (Registrar's signature)

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.....

P. O. Address.....

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.