No. 2
—2-43
5-17-10
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 11 1943

Registration District No. 3 8

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 306-5-20

State File No. 31151

Registrar's No. 2-26

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: no
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: Life

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.: 702 N 7th St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country: x

3. (a) PRINT FULL NAME: Minnie M. Gholson

3. (b) If veteran, name war: no

3. (c) Social Security No.: x

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: James Oscar Gholson

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

7. Birth date of deceased: Sept (Month) 2 (Day) 1882 (Year)

8. AGE: Years: 61 Months: x Days: 3 If less than one day ____ hr. ____ min.

9. Birthplace: Callaway Co. (City, town, or county) Mo (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: " "

MOTHER FATHER
12. Name: Charlie Davis
13. Birthplace: Indiana (City, town, or county) (State or foreign country)
14. Maiden name: Angeline Hicks
15. Birthplace: Indiana (City, town, or county) (State or foreign country)

16. (a) Informant: J O Gholson
(b) Address: Columbia Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 7-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Old Cedar

18. (a) Signature of funeral director: R Overton
(b) Address: Columbia Mo

19. (a) 9/17 (Date received local registrar) (b) E R Carter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept day: 5th year: 1943 hour: 10 PM minute: P. M.

21. I hereby certify that I attended the deceased from 6-10- 1943, to Sept 5- 1943, that I last saw h. alive on Sept 1 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma F Lum. Intestines etc, 8 2 yrs

Due to: ____

Due to: ____

Other conditions (Include pregnancy within 3 months of death): ____

Major findings: Of operations: None

Of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): No
(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: W. D. Depew (M.D. or other)
Address: Columbia Mo Date signed: 9-24-43

125.0

(Licensed Embalmer's Statement on Reverse Side)

43

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. 31183

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.