

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Smith 34100*

FILED NOV 13 1943
Registration District No. *1248*

Primary Registration District No. *3006*

Registrar's No. *250*

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 *Willard Convalescent Home 4*
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution *19 Months*
 (Specify whether
 In this community *74 Years*
 years, months or days)

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. *104 Ripley St.*
 (If rural, give location)
 (e) Citizen of foreign country? *No* (Yes or No)
 If yes, name country. *0*

3. (a) PRINT FULL NAME *ISABELLE WESTBROOK*
 3. (b) If veteran, name war. *None*
 3. (c) Social Security No. *None*

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month *Oct.* day *18*
 year *1943* hour *3:20* minute *A.* M.

4. Sex *Female*
 5. Color or race *White*
 6. (a) Single, widowed, married, divorced *Widowed*
 6. (b) Name of husband or wife *Willard Westbrook*
 6. (c) Age of husband or wife if alive *years*
 7. Birth date of deceased *11 - 13 - 1868*
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *Oct 17* 19*43* to *Oct 18* 19*43*
 that I last saw him alive on *Oct 17*
 and that death occurred on the date and hour stated above.

8. AGE: Years *74* Months *11* Days *5*
 If less than one day
 hr. min.

Immediate cause of death
myocardites
General Arterio sclerosis
Old Age

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

Due to *Old Age*

10. Usual occupation *Retired*

Other conditions (Include pregnancy within 3 months of death)
92el

MOTHER FATHER }
 11. Industry or business
 12. Name *Henry Creasy*
 13. Birthplace *Unknown*
 (City, town, or county) (State or foreign country)
 14. Maiden name *Fannie Waller*
 15. Birthplace *Missouri*
 (City, town, or county) (State or foreign country)

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

16. (a) Informant *Ruby Mordecai*
 (b) Address *Farmington, Mo.*

17. (a) *Burial* (b) Date thereof *10-20-43*
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Columbia Cemetery*

18. (a) Signature of funeral director *Barber Funeral Service*
 (b) Address *Columbia, Mo.*

19. (a) *10-20-43* (b) *G. Adora H. Barber*
 (Date received local registrar) (Registrar's signature)

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?

23. Signature *Stetson Stewart* (M. D. or other)
 Address *Columbia* Date signed

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

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. W. Petrides

Licensed Embalmer No.

3893

P. O. Address

Columbia

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.