No. 2
12-45
17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 19 1946

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 43302

Registration District No. 358 Primary Registration District No. 6215 Registrar's No. 26

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Rural, Osage Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 9
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Newton 73
(c) City or town Camp Crowder 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME HERVEY DOW COLUMBIA
3. (b) If veteran, name war World War I
3. (c) Social Security No.
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Eva E. Columbia
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 2 (Day) 1903 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 6 | 7 | hr. min. |

9. Birthplace Unknown (City, town, or county) (State or foreign country)
10. Usual occupation United States Army
11. Industry or business
FATHER
12. Name Mr. P. J. Columbia 9
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9
MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9
16. (a) Informant War Department records
(b) Address
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 10 1946 (Month) (Day) (Year)
(c) Place: burial or cremation Leavenworth, Kans.
18. (a) Signature of funeral director Marsh Eichinger Funeral Home
(b) Address Nevada, Mo.
19. (a) Dec. 18 1946 (Date received local registrar) (b) Mrs. Sarah E. Gray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 9 year 1946 hour 8:00 minute P.M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Broken Neck, internal injuries | |
| Due to Auto & Truck accident | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy No | |

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) Accident 100
(b) Date of occurrence 12-9-46
(c) Where did injury occur? 71 Highway (City or town) Vernon (County) Mo. (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway (Specify type of place)
While at work? (e) Means of injury Auto Accident
23. Signature Marsh Eichinger (M. D. or other) Coroner 3
Address Nevada Mo. Date signed 12-11-46

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 11-46-3114
Date Filed 12-14-46

**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 Marsh Eichinger

Licensed Embalmer No. 2656

P. O. Address Nevada, Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

S. No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 35-8 Primary Registration District No. 6215 Registrar's No. 26

1. PLACE OF DEATH:
(a) County Vernon
(b) City or town Rural
(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 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Hervey D. Columbia
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 2 1896 (Month) (Day) (Year)
8. AGE: Years 43 Months Days If less than one day hr. min.
9. Birthplace (City, town, or county) Unknown (State or foreign country)
10. Usual occupation Army
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Jan 14-1947 (Date received local registrar) (b) Mrs Sarah E. Gray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day Year 1946 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.
Immediate cause of death — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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)
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY 9

S-43302