

No. 2  
5-43  
17-39  
X3687

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 5 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 127

Registration District No. 38

Primary Registration District No. 3006

Registrar's No. 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:  
Home - no 700 North 8th St  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community Life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10

City or town Columbia 2  
(If outside city or town limits, write "RURAL")

(d) Street No. 700 N 8th 4  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARGARET Phena Crist

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife George D Crist

6. (c) Age of husband or wife if alive 4 years

7. Birth date of deceased Nov 6 1867  
(Month) (Day) (Year)

8. AGE: Years 80 Months 2 Days 18  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Cape Girardeau Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Charles Coleman

13. Birthplace DK  
(City, town, or county) (State or foreign country)

14. Maiden name Coralee Mullins

15. Birthplace DK  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Robt Mitchell

(b) Address Route 2 Columbia Mo

17. (a) Burial (b) Date thereof Jan 27-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director R Owen

(b) Address Columbia Mo

19. (a) 1-28-48 (b) Mrs R E Palmer  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 24  
year 1948 hour 1 minute 15 A. M.

21. I hereby certify that I attended the deceased from 1-19  
1948 to 1-27 1948

that I last saw him alive on \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Common  
stroke  
Mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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?  
No (Specify type of place)

While at work? No (e) Means of injury \_\_\_\_\_

23. Signature W T Wright M. D. or other \_\_\_\_\_

Address Columbia Mo signed \_\_\_\_\_

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

Date Filed FEB 3 1948

District Health Officer No. 9,  
RECEIVED

**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: *[Handwritten Signature]*

Licensed Embalmer No. *3183*

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.**

Registration District No. 38

Primary Registration District No. 3006

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columb  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Margaret P. Crist

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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 \_\_\_\_\_

7. Birth date of deceased m . 6  
(Month) (Day) (Year)

8. AGE: Years 80 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
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) 1-28-48 (b) Mrs. R. E. Palmer  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

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