

FILED JUL 22 1948

Registration District No. **38**Primary Registration District No. **3006**Registrar's No. **193**

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 **Boone County Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 Hour**
(Specify whether **1 Hour**)

In this community **50 Years**
(years, months or days)

3. (a) PRINT FULL NAME **WILLIAM A. VANCE**

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

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

4. Sex **Male**

5. Color or race **White**

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

6. (b) Name of husband or wife

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

7. Birth date of deceased **Unknown**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

80 **Unknown** **Unknown** **Unknown** hr. min.

9. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Fred Beaven**

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

17. (a) **Burial** (b) Date thereof **7-10-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Parsons Funeral Service**

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

19. (a) **July 14, 1948** (b) **Mrs. R.E. Palmer**
(Date received local registrar) (Registrar's signature)

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. **108A N. 8th St.**
(If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **8**
year **1948** hour **6** minute **30 P.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cancer of Esophagus

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations **H&W**

Of autopsy _____

PHYSICIAN

Underline the cause of 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 _____ (c) Means of injury _____

23. Signature **J. H. [Signature]**

Address **Columbia, Mo.** Date signed **7/12/48**

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
David H. North
JUL 21 1948
Date Filed

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..... *Tom M. Harg*

Licensed Embalmer No. *4067*

P. O. Address. *Columbus*

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

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