

No. 300
-10-47
5-17-39
-1 3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 1 1948
Registration District No. 38

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28860
Registrar's No. 234

Primary Registration District No. 3006

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Columbia, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
303 Waugh St. Columbia-Mo.
(If not in hospital or institution; write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 10 years.
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Columbia, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 303 Waugh St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Nancy Jane DeLaPorte
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 7
year 1948 hour 5 minute 30 P.M.
21. I hereby certify that I attended the deceased from June
_____, 1948 to Sept _____, 1948
that I last saw her alive on Sept 7, 1948
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife J. C. DeLaPorte
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Oct 13 1857
(Month) (Day) (Year)

Immediate cause of death
Myocardial Insufficiency
Due to Senile Complications

8. AGE: Years Months Days If less than one day
90 10 24 hr. _____ min.

Duration
5 wks.
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

9. Birthplace Ralls County Mo.
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

Major findings:
Of operations MI
Of autopsy _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business Home
12. Name John Barr 4
13. Birthplace _____ Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mrs. Shaver
15. Birthplace _____ Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Clyde Johnson
(b) Address Columbia, Mo.

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? _____

17. (a) Burial (b) Date thereof Sept. 10, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Laddonia Cemetery
18. (a) Signature of funeral director Clyde C. Wilkey
(b) Address Laddonia, Mo.
19. (a) 9-20-48 (b) Mrs. R.E. Palmer
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury L
23. Signature R. E. Palmer (M-D. or other) DO
Address Columbia, Mo. Date signed 9-2-48

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed SEP 30 1948

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 Clyde Wilsey
Licensed Embalmer No. 3820
P. O. Address Perry, Mo.

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.