'CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Marion Co

Township Round Grove

or Village Steffenville

or City _____ (NO. _____, _____ St. _____ Ward)

Registration District No. 551 ~~485~~

Primary Registration District No. 5744

File No. 7130

Registered No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME × Claude Wesley Bohon

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH: × July (Month) 12 (Day), 1910 (Year)

AGE: _____ yrs. 6 mos. 27 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION × (a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) × 0 741 1060

BIRTHPLACE (City or town, State or foreign country) × Marion County

PARENTS

NAME OF FATHER × W D Bohon

BIRTHPLACE OF FATHER (City or town, State or foreign country) × Marion County

MAIDEN NAME OF MOTHER Kate Ravenscraft

BIRTHPLACE OF MOTHER (City or town, State or foreign country) × Marion County

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W D Bohon

(ADDRESS) Nelsonville Mo

Filed Feb. 6, 1911 J M Crebs REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb (Month) 4 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 21, 1910, to Feb 4, 1911, that I last saw him alive on Feb 7, 1911, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Meningitis complicated by Bronchitis

(Duration) _____ yrs. _____ mos. 5 ds.

Contributory (SECONDARY) Cold

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. F. Sole M. D.

Feb 4, 1911 (Address) Steffenville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: New Providence

DATE OF BURIAL: Feb 5 1911

UNDERTAKER: E. Steffen

ADDRESS: Steffenville

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

inty.....

vnship .....

age.....

y .....(NO. ....., ...St.; .....Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

N. B.—Every item of information should be carefully supplied. Avoid abbreviations. Write out words in full. Especially should the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH

.....(Month) .....(Day), *1*.....(Year)

AGE .....yrs. .....mos. .....ds. | If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....(Month) .....(Day), *191*.....(Year)

I HEREBY CERTIFY, that I attended deceased from .....191....., to .....191.....,

that I last saw h.....alive on .....191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory
(SECONDARY) .....

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS