N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state 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 28353-a

PLACE OF DEATH

County: Knox

Township or Village or City: Lyon

Registration District No. 443 File No. 17

Primary Registration District No. 5601-B Registered No. 17

(No. ______ St.; ______ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Ben Franklin Boone.

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH
SEX: Male	COLOR OR RACE: White	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married	DATE OF DEATH: Aug (Month) 1 (Day), 1916 (Year)

DATE OF BIRTH: May (Month) 14 (Day), 1830 (Year)

AGE: 86 yrs. 2 mos. 17 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

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

BIRTHPLACE (City or town, State or foreign country): Ohio

PARENTS

NAME OF FATHER: ~~Nat~~ Joseph Boone

BIRTHPLACE OF FATHER (City or town, State or foreign country): Not Known

MAIDEN NAME OF MOTHER: Not Known

BIRTHPLACE OF MOTHER (City or town, State or foreign country): ~~J. Wy~~ Not Known

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Boone

(Address) Hurdland Mo.

Filed Aug 1, 1916 B F Humphrey REGISTRAR

I HEREBY CERTIFY, that I attended deceased from no, 191__ attendance, 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:

Death was supposed to be from appoplexy

(Duration) ___ yrs. ___ mos. 2 ds.

Contributory (Secondary) old age

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

(Signed) B F Humphrey, M.D.

Aug 1, 1916 (Address) Hurdland

*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
Baker Cemetery	8-2-1916
UNDERTAKER	ADDRESS
F. W. Magruder	Hurdland Mo.

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

Revised United States Standard Certificate of Death

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

(NO.....St.;.....Ward)

[If death occu
hospital, or in
give its NAME
of street and nu

FULL NAME.....

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),

I HEREBY CERTIFY, that I attended deceased

....., 191...., to.....,

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

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed).....

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

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSI
RECENT RESIDENTS)

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS