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

20261

PLACE OF DEATH

County: Douglas

Township: ~~Bentley~~

or ~~Village~~: ~~Ava~~

or City: Ava (NO. ____ St.; ____ Ward)

Registration District No. 272 File No. ____

Primary Registration District No. 4165 Registered No. 44

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

FULL NAME: Arthur C Boman

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Oct (Month) 24 (Day), 1879 (Year)

AGE: 41 yrs. 6 mos. 23 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work: Real Elst Agt
(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): Glen Alvin Mo.

PARENTS

NAME OF FATHER: Miles W Boman

BIRTHPLACE OF FATHER (City or town, State or foreign country): Do not know

MAIDEN NAME OF MOTHER: Do not know

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Do not know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): C W Meeker

(ADDRESS): Ava Mo

Filed Sept 8, 1921. R M Norman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug (Month) 17 (Day), 1921 (Year)

I HEREBY CERTIFY, that I attended deceased from July 22, 1921, to Aug 16, 1921, that I last saw him alive on Aug 16, 1921, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis 23A

(Duration) — yrs. 10 mos. — ds.

Contributory (SECONDARY): None.

(Duration) — yrs. 10 mos. — ds.

(Signed) J L Gentry M. D.

Aug 31, 1921 (Address) Ava Mo

*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? Cape Gerardeau Mo

Former or usual residence: Cape Gerardeau Mo

PLACE OF BURIAL OR REMOVAL: Ava Cemetery

DATE OF BURIAL: Aug 18, 1921

UNDERTAKER: W. R. Clemmingbeard

ADDRESS: Ava Mo

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

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (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 _____

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