LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

Dr Teague
Mar 17 8409

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

1. PLACE OF DEATH

County Henry — Registration District No. 350 — File No.
Township — Primary Registration District No. 3218 — Registered No. 50
City Clinton (No. 1160 St. Ward)

2. FULL NAME Sam Boggs

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word):

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 8 1920

7. AGE — YEARS: 1 — MONTHS: 7 — DAYS: 9 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Dyersburg Co
(STATE OR COUNTRY) Tenn

PARENTS

10. NAME OF FATHER Sam Boggs
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Clinton Mo
12. MAIDEN NAME OF MOTHER Roena Hibbs
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mansfield
(STATE OR COUNTRY) Kansas

14. INFORMANT Sam Boggs
(Address) Clinton Mo

15. FILED 4/3 1922 Ed C Peeler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 17 1922

17. I HEREBY CERTIFY, That I attended deceased from Mar 8, 1922, to Mar 17, 1922 that I last saw h.. alive on Mar 17, 1922 and that death occurred, on the date stated above, at 6 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia Cause
from flu
11 "
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) NO
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED —
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? —
WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) Daniel A Pearce, M. D
3/21, 1922 (Address) Clinton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Clinton Mo — DATE OF BURIAL: Mar. 19 1922

20. UNDERTAKER: Sims Wilkerson Co — ADDRESS

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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County [redacted] Registration District No. ..... File No. .....

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

City [redacted] (No. ..... St. ..... Ward)

2. FULL NAME [redacted]

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX [redacted]

4. COLOR OR RACE [redacted]

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) [redacted]

7. AGE — YEARS [redacted] MONTHS ..... DAYS ..... If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work [redacted]

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

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) [redacted]
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER [redacted]

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) [redacted]

12. MAIDEN NAME OF MOTHER [redacted]

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) [redacted]
(STATE OR COUNTRY) [redacted]

14. INFORMANT [redacted]
(Address) [redacted]

15. FILED ....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL ..... DATE OF BURIAL 19

20. UNDERTAKER ..... ADDRESS .....

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.