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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

6679

PLACE OF DEATH

County: Andrew

Township: Platte

or Village:

or City: (NO. St.: Ward)

Registration District No. 15

Primary Registration District No. 5019

File No.

Registered No. 3

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

FULL NAME William E Bostwick

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: Jany 29, 1846 (Month) (Day) (Year)

AGE: 78 yrs. 1 mos. 9 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): Canada

PARENTS

NAME OF FATHER: Chas G Bostwick

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

MAIDEN NAME OF MOTHER: Elvira Manning

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Bella Slanson

(ADDRESS): Rea Mo

Filed Mar 10, 1924 E C Jeffries
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: March 7, 1924 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 7, 1923, to Mar 7, 1924, that I last saw him alive on Mar 7, 1924, and that death occurred, on the date stated above, at 12-10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

131 (Duration) 2 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) E C Jeffries M. D.

3/7 1924 (Address) Whitesville

*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: Savannah Mo

DATE OF BURIAL: Mar 9 1924

UNDERTAKER: Terhune

ADDRESS: Savannah

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

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.