PLACE OF DEATH

County Howard

Township or Village Boonsboro or City (NO. St.; Ward)

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

31579

Registration District No. 377 File No.

Primary Registration District No. 4221 Registered No. 710

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

FULL NAME Luther C. Kivett

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: June (Month) 12 (Day), 1871 (Year)

AGE: 53 yrs. 4 mos. 27 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Boonsboro Mo

PARENTS
NAME OF FATHER: J. S. Kivett
BIRTHPLACE OF FATHER (City or town, State or foreign country): N. C
MAIDEN NAME OF MOTHER: Lizzie McCart
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Howard Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs L. C. Kivett

(ADDRESS) Boonsboro

Filed Nov 14th 1924 Thos Finn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov (Month) 12 (Day), 1924 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch, 1924, to Nov, 1924 that I last saw him alive on Nov 10, 1924 and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

~~Acute~~ Nephritis Chronic 129
131
95B (Duration) ___ yrs. 2 mos. ___ ds.

Contributory (SECONDARY) Dilatation of heart (Duration) ___ yrs. 3 mos. ___ ds.

(Signed) W. O. Hawkinson M. D.

11-12, 1924 (Address) Roanoke 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?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Boonesboro Mo

DATE OF BURIAL: Nov 14th 1924

UNDERTAKER: W. J. Miller

ADDRESS: Fayette 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.

REGISTRARS SHALL NOT RECEIVE

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

MISSOURI STATE BOARI
BUREAU OF VITAL ST
CERTIFICATE OF DE

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registered No. _____
or
City _____ (NO. _____ _____ St.; _____ Ward)

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____, 1_____
(Month) (Day) (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 DI

DATE OF DEATH _____
(Month)

I HEREBY CERTIFY, that I att
_____, 191____, to _____
that I last saw h_____ alive on _____
and that death occurred, on the date stated
The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____

(Signed) _____

_____, 191____ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIO RECENT RESIDENTS)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE
UNDERTAKER	ADDRE

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name ori-