

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

27287

PLACE OF DEATH
 County Jasper Co. Registration District No. 411 File No. 412
 Township _____ Primary Registration District No. 2002 Registered No. _____
 City Joplin Mo (No. _____) St. _____ Ward _____

FULL NAME Dewey Otis Booe
 (a) Residence. No. 801 Wall St 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

SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
27 July 16
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work miner
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 10 1927
 17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1927, to Sept 10, 1927, that I last saw him alive on Sept 9, 1927, and that death occurred, on the date stated above, at 6 A M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

10/10
10/10
10/10
 (duration) yrs. mos. ds.

CONTRIBUTORY Peritonitis
 (SECONDARY)
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? yes DATE OF Aug 3 - 1927
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? Physical findings
 (Signed) A Mitchell Thayer M. D.
9-10-1927 (Address) Joplin 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.)

9. BIRTHPLACE (CITY OR TOWN) Galena
 (STATE OR COUNTRY) Kansas
 10. NAME OF FATHER John D Booe
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Martha Buchanan
 BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill
 (STATE OR COUNTRY) _____
 DECEASED (Address) John D Booe
Galena Kansas
 FILED _____ 19 _____ REGISTRAR _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Clark Hill Crest DATE OF BURIAL Sept 13 1927
 20. UNDERTAKER P M Clark ADDRESS Galena Kansas

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CERTIFICATE OF DEATH**

1. PLACE OF DEATH
 County Jasper File No.
 Township Jasper, Mo. Registered No.
 City Jasper, Mo. (No.) St.
 2. FULL NAME Darney Boone
 (a) Residence, No. 801 N. 1st St.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos.
 Length of residence in city or town where death occurred yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. If MARRIED, WIDOWED, OR DIVORCED (OR) HUSBAND OF WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) | MONTHS | DAYS | IF LESS than 1 day, hrs. or min.
27 | July | 16 |

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

10. NAME OF FATHER John Boone

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ill.

12. MAIDEN NAME OF MOTHER Martha Buchanan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill.

14. INFORMANT (Address) John Boone
Gallatin, Kansas

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 10
 17. I HEREBY CERTIFY, That I attended deceased from
 that I last saw h. alive on 3/19/20
 death occurred, on the date stated above, at.....
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos.
 (duration) yrs. mos.

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

*State the DISEASE CAUSING DEATH, or in death from Violent Cause,
 (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDE
 HOMICIDE. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BU
Clark Hull Crest Sept 11
 20. UNDERTAKER ADDRESS Clark Hull Crest
S.M. Clark
Dr. Thiggy

FILED..... 19..... REGISTRAR

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

Matchless

1. PLACE OF DEATH.

County Jasper

Registration District No. 411

File No.

Township

Primary Registration District No. 2002

Registered No.

City Joplin (No.)

St. Ward)

2. FULL NAME

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 23rd 1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
27 July 16

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) (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED Sept 25 12 A. Benson Clark REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept-10-1925

17. I HEREBY CERTIFY, That I signed the above (date) July 27-27

(that I last saw him alive on) 1-23-1897 and that death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. d.

(duration) yrs. mos. d.

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.

, 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

20. UNDERTAKER ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

FILED WITH 153

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

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespectively of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

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... of which surg...
... VIOLENT DEATH...
... ACCIDENT...
... probably such, i...
... Examples:
... railway train—accident;
... Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory."
(Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

Name: Henry Otis Boole

Who died at: Jaffin on Sept 10-1925

Residence No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Result of operation for perforated appendix

Contributory: _____ 117A

Where was disease contracted? _____

Did operation precede death? yes Date of _____

Was there an autopsy? _____ What test confirmed diagnosis? _____

Name of physician: _____

Address of physician: _____

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