

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

Do not use this space.

36592

**1. PLACE OF DEATH**

County Missouri Registration District No. 318

Township Springfield Primary Registration District No. 5440

City Springfield (No. R.D. 49)

File No. \_\_\_\_\_

Registered No. 781

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. H.D. 157 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 full word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 17, 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
10 2 0

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work chief

(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) Mo.

PARENTS

10. NAME OF FATHER Dwight W. Boney

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

12. MAIDEN NAME OF MOTHER Louis Cook

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

14. INFORMANT Dwight W. Boney (Address) # 19

15. FILED 12/21/27 Ch. Horat REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-17 1927

17. I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1927, to 12-17-27 that I last saw him alive on 12-17-27 and that death occurred, on the date stated above, at 2:20 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hepatitis or Absence of Bill ducts.  
16 1/2 (duration) 4 yrs. 13 ds.

CONTRIBUTORY (SECONDARY) 12 4 13 (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? no

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) C. E. Kelley, M. D. (Address) Springfield 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Springfield DATE OF BURIAL 12-18-27

20. UNDERTAKER W. Horat ADDRESS Springfield 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.

