

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

Do not use this space. **492**

**FEB 20 1928**

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.

**1. PLACE OF DEATH**

County Christian Registration District No. 187 File No. \_\_\_\_\_  
 Township Wagon Tail Primary Registration District No. 5287 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (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 single  
 6a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 29 - 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 3 hrs. or — min.

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work None  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Ballwin (STATE OR COUNTRY) Mo

10. NAME OF FATHER W. R. Boden

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

12. MAIDEN NAME OF MOTHER Delone Williams

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

14. W. R. Boden (Address) Ballwin Mo

15. FILED 2/10 1928 A. J. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 to Jan 9, 1928, that I last saw him alive on Jan 8, 1928, and that death occurred, on the date stated above, at 2 P. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

159 Primate Birth  
 (duration) yrs. mos. ds. \_\_\_\_\_  
 CONTRIBUTORY (SECONDARY) ICIA  
 (duration) yrs. mos. ds. \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? no test  
 (Signed) Sturtevant, M. D.  
 , 19 (Address) Claver 418

\*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, DATE OF BURIAL  
Rose Hill - Jan 10 1928

20. UNDERTAKER W. R. Boden ADDRESS \_\_\_\_\_

