

MAR 26 1928

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

Do not use this space.

10108.

1. PLACE OF DEATH *Phelps Co.* Registration District No. *677*
 County *Phelps Co.* Township *Rolla* Primary Registration District No. *4403*
 City *Rolla* (No. *.....*) St. *.....* Ward *.....*

2. FULL NAME *Matilda Jane Booz*
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of *W. J. Booz*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 18, 1861*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 8 22

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

9. BIRTHPLACE (CITY OR TOWN) *Chapman Co. Ill.*
 (STATE OR COUNTRY)

10. NAME OF FATHER *Jane Carter*

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

12. MAIDEN NAME OF MOTHER *Polley Huffman*

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3-4 1928*

17. I HEREBY CERTIFY, That I attended deceased from *2/19/28* 19... to *3/4/28* 19... that I last saw *.....* alive on *3/4/28* 19... and that death occurred, on the date stated above, at *.....* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Obstructed arteries in the left leg

18. WHERE WAS DISEASE CONTRACTED? (duration) yrs. mos. da.
9911

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

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH? *.....*

19. DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *2/20/28*

20. WAS THERE AN AUTOPSY? *.....*

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) *Walter McFarland*, M. D.
Mar 5, 1928 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *St. James Mo* DATE OF BURIAL *3-6 1928*

20. UNDERTAKER *W. G. Lechler* ADDRESS *St. James Mo*

14. INFORMANT *W. J. Booz*
 (Address) *Litch, Mo*

15. FILED *Mar 5, 1928* *J. F. Ayers* REGISTRAR

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.

