

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.

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

Do not use this space.

1719

1. PLACE OF DEATH

County Jackson
Township 1st Kan
City Kansas City (No. St. Bonker Hospital)

Registration District No. 399Primary Registration District No. 1002

File No. 611
Registered No. 611
St. St. Bonker Hospital Ward 15

2. FULL NAME

Robert Clifford Boan
(a) Residence. No. 6216 Forest St. 15 Ward.

(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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

Jan. 20th 1929

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ____ hrs. ____ min.

8. OCCUPATION OF DECEASED

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

Student

(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 City, Mo.

10. NAME OF FATHER

Clifford O. Boan

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Ruth Matson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14.

INFORMANT Clifford O. Boan
(Address) 6216 Forest Ave

15.

FILED 1-22-29 M. M. Cruise
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan. 20th 1929

17. I HEREBY CERTIFY, That I attended deceased from

Jan 20, 1929 to Jan 21, 1929
that I last saw him alive on Jan 21, 1929 and that death occurred, on the date stated above, at 11:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
1608 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)

difficult Inceps (duration) yrs. mos. da.
and R.O.P.

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)

D. J. Haulton M. D.

(Address)

602 E. 19th St

*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

Forest Hill1/23/ 1929

20. UNDERTAKER

ADDRESS

Freeman Mortuary
104 W. 42nd St

St. Louis, Mo.