

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

Do not use this space.

9611

**1. PLACE OF DEATH**

County.....Buchanan.....  
Township.....  
City.....St. Joseph..... (No. 2507 North 7th Street)

Registration District No. 85  
Primary Registration District No. 1001

File No. ....  
Registered No. 3/6 .....  
St. .... Ward)

**2. FULL NAME** Benjamin Booher

(a) Residence. No. 2507 No. 7th Street St., ..... Ward. ....  
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**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 HUSBAND OF Laura Booher (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 8, 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>68</u>	<u>13</u>	<u>29</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Retired Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Bloomfield  
(STATE OR COUNTRY) Indiana

10. NAME OF FATHER Abraham Booher

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

12. MAIDEN NAME OF MOTHER Lydia Padget

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

14. INFORMANT Mrs. Laura Booher  
(Address) 2507 No. 7th Street

15. FILED John G. Galt REGISTRAR  
1929

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 7 19 29

17. I HEREBY CERTIFY, That I attended deceased from 3/5/29, 19....., to 3/7/29, 19....., and that I last saw him alive on 3/5/29, 19....., and that death occurred, on the date stated above, at 3-15 A m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Bronch. Pneumonia  
99.9  
107.0  
77 (duration) ..... yrs. mos. da. 5  
CONTRIBUTORY Arterio Sclerotic Hemiplegia  
(SECONDARY) (duration) 2 yrs. mos. da.

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? Phys Exam, x-ray

(Signed) [Signature], M. D.

Mar. 7, 1929 (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 DATE OF BURIAL

Burlington Jct. Mo.

Mar. 9 19 29

20. UNDERTAKER

ADDRESS

H. O. Sidenfaden 4429

1802 Union St.

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.

11  
23  
929  
9  
1  
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