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

Do not use this space.

15725

1. PLACE OF DEATH
County Dade — Registration District No. 237
Township — Primary Registration District No. 4144
City Greenfield — No. ____ St. ____ Ward)

File No. ____
Registered No. 25

2. FULL NAME Victor James Boone

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 29-1927

7. AGE. YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
3	.	21	

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) None
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Lowry W Boone
11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER May D Marsh
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
(STATE OR COUNTRY) Mo

14. INFORMANT May D. Boone
(Address) Greenfield Mo

15. FILED 6/10, 1930 E O Ball REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 20 1930

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____, that I last saw h. alive on May 20, 1930, and that death occurred, on the date stated above, at 1:50 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Infantile paralysis
(duration) ____ yrs. 4 mos. ____ ds.

CONTRIBUTORY (SECONDARY)
(duration) ____ yrs. ____ mos. ____ ds.

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) [illegible] M. D
, 19 (Address) Aurora 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 Greenfield Cemetery — DATE OF BURIAL May 21 1930

20. UNDERTAKER Harrison Undertaking Co — ADDRESS Greenfield 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.