

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

1. PLACE OF DEATH

County Boonville
Township Smith
City (No. _____) _____ St. _____ Ward _____

Registration District No. 903
Primary Registration District No. 0311

File No. 11750-A
Registered No. _____

2. FULL NAME

(a) Residence Boonville, Mo. St. _____ Ward _____
(Usual place of abode)

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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
96 11 27

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Chautauque Co. N. Y.
(STATE OR COUNTRY)

10. NAME OF FATHER Henry Conn

11. BIRTHPLACE OF FATHER (CITY OR TOWN) New York
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Charcella Conn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not obtained
(STATE OR COUNTRY) New York

14. INFORMANT Charcell Conn
(Address)

15. FILED March 1934

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19 34

17. I HEREBY CERTIFY That I attended deceased from Dec 15 1931 to March 2 1934
that I last saw him alive on March 2 1934, and that death occurred, on the date stated above, at 1:15 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis of R. Foot
Prostatic Hypertrophy
Prostatic

CONTRIBUTORY (SECONDARY) None

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) Frederick H. Mull M. D.
, 19 (Address) MULL

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

First Cemetery 3-5-1934
J. J. Anderson Boonville

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PE-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPAT-

MISSOURI STATE BOARD OF HEALTH

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.)..... St..... Ward.....

2. FULL NAME

(a) Residence, No..... St..... Ward.....
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. (If nonresident give city or town and State)
 How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

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

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

PARENTS

14. INFORMANT.....
 (Address).....

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from.....

that I had saw h..... alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at.....
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED.....
 IF NOT AT PLACE OF DEATH..... DATE OF.....
 DID AN OPERATION PRECEDE DEATH.....
 WAS THERE AN AUTOPSY.....
 WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed)....., M.D.
 , 19 (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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

STATE OF MISSOURI,
COUNTY OF WORTH, SS

Dr. Fred Mull, being first duly sworn, upon his oath states that the attached certificate is true and correct according to the original death certificate of Spencer Connors filed in my office.

Fred Mull MD

Subscribed and sworn to before me this 21st day of July, 1934.

My com. expires June 3rd, 1936.

Hattie B Viles
Notary Public of Worth
County, Missouri.

S(2)11750-A

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking on the death certificate.

North Smith
Name of deceased Spencer Bonn
Died at Worth, Mo on Mar 2, 1934
Residence: No. Alledale St. Mo
Place of residence in city or As near as I can find out June 1867
where death occurred: Years 96 Months 11 Days 27
Color or race W Single, married, widowed or divorced: Single
Date of birth March 6 - 1837 Age:) Years 96 Months 11 Days 27
Occupation: (a) Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc. Last occupation (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. no
Where deceased last worked at this occupation: Month About 20 years ago Year 1914
Place (State or country) Chautauque, New York State
Place of father (State or country) New York State
Place of mother (State or country) not stated
Principal cause of death: Gangrene of foot
Other contributory causes of importance: Diabetes
Name of operation none Date of hypertrophy of arteries
What test confirmed diagnosis? none Was there an autopsy? yes
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? no Date of injury 19
Where did injury occur? none
(Specify city or town, county and State)

Indicate whether injury occurred in industry, in home, or in public place. no

Name of physician none
Nature of injury none
Was disease or injury in any way related to occupation of deceased? no
If so, specify no
Name of physician Frank M. Mull M.D.
Address of physician Grand St. E. Mo.
Signature of Registrar Frank M. Mull Reg.

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 903

Very truly yours,

Primary Reg. Dist. No. 6211

E. T. McGaugh
Special Agent.
M.S. M.

S-811750-A