

*Dr. Coakley*

Do not use this space.

42618

File No. *626*  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

JAN 2 1935

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

1. PLACE OF DEATH

County *St. Louis*  
Township *Quincy*  
City *St. Louis* (No. *1000*)

Registration District No. *318*  
Primary Registration District No. *2001*

2. FULL NAME

(a) Residence, No. *Wagnerville Mo.* St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Care H. Bohanon*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 4 - 1900*

7. AGE YEARS *34* MONTHS *4* DAYS *10* IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housewife*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Richland Mo.*

13. NAME *H. E. Hawleth*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

15. MAIDEN NAME *Mary Leeds*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

17. INFORMANT *Care H. Bohanon* (ADDRESS) *Wagnerville*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Richland* DATE *12/15* 1934

19. UNDERTAKER *Edmund Bohanon* (ADDRESS) *Springfield, Mo.*

20. FILED *12-15-1934*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12-14*, 1934

22. I HEREBY CERTIFY, that I attended deceased from *Dec 14*, 1934, to *Dec 15*, 1934  
I last saw her alive on *Dec 14*, 1934. Death is said to have occurred on the date stated above, at *3:30 PM*  
The principal cause of death and related causes of importance were as follows:

*acute leukemia*  
*obstruction of bowels*  
*1930*

Other contributory causes of importance:  
*post-operative ad-*  
*hesions*

Name of operation *ligation of bowels* Date of *12/14/34*  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) *Dr. Coakley*, M. D.

(Address) *Springfield, Mo.*

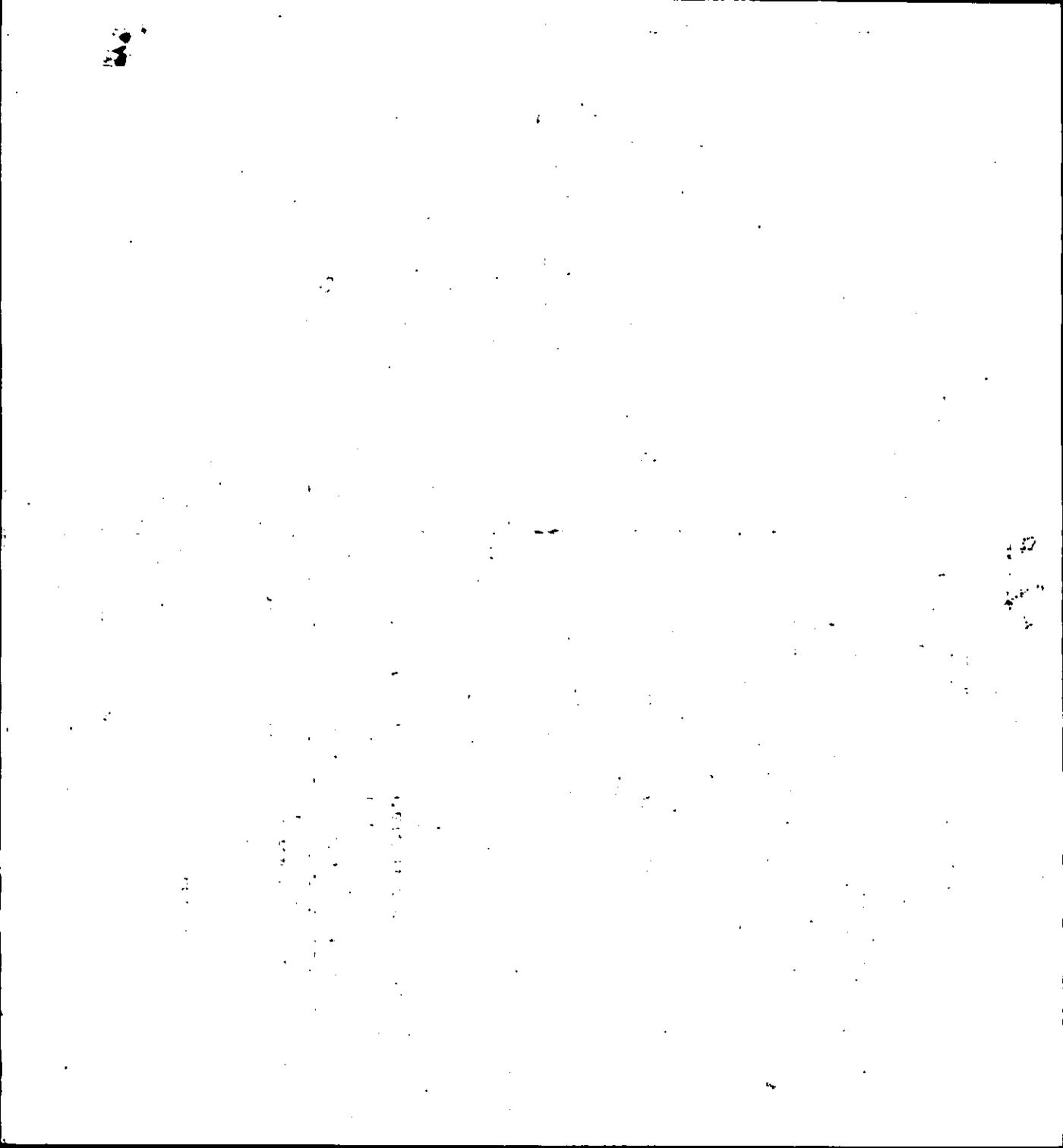
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

*35*  
*5*

*23*

*1*

*Edmund Bohanon*  
*Richland, Mo.*



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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Greene

Registration District No. 318

Township

Primary Registration District No. 200

City Springfield (No. 1)

Ward 200

File No. \_\_\_\_\_

Registered No. 626

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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**

**MEDICAL CERTIFICATE OF DEATH**

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 14, 1934

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 34 4 10

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ Total time (years) spent in this occupation \_\_\_\_\_

as Intestinal obstruction Date of onset \_\_\_\_\_

Other contributory causes of importance:

Post operative adhesion

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Name of operation For relief of obstruction Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 1-31, 1934

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

**SUPPLEMENTARY**

*John P. ...*  
*Physician to ...*

JAN 29 9 1935

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