

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

Do not use this space.

DEC 26 1935

38273

1. PLACE OF DEATH

County Franklin Registration District No. 824
Township Summit Primary Registration District No. 6076
City (No. _____) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

William L. Boatner, Boatner
(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 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 Beatrice R. Boatner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb - 1 - 1889

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>76</u>	<u>9</u>	<u>5</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Stone Mills
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) Cape Girardeau Mo

13. NAME William L. Boatner

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

15. MAIDEN NAME M. L. Gholson

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

17. INFORMANT (ADDRESS) Frank Boyd, 110 _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Aranda DATE 11 - 7 - 1935

19. UNDERTAKER (ADDRESS) Boatner, Mo

20. FILED 11 - 6 - 1935 Frank Boyd MD Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov - 6 - 1935

I HEREBY CERTIFY, That I attended deceased from Sept - 1 - 1935 to Nov - 6 - 1935

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 4 a m.

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

Myocardial Infarction following
hypertension
and
angina pectoris

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external cause (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 _____

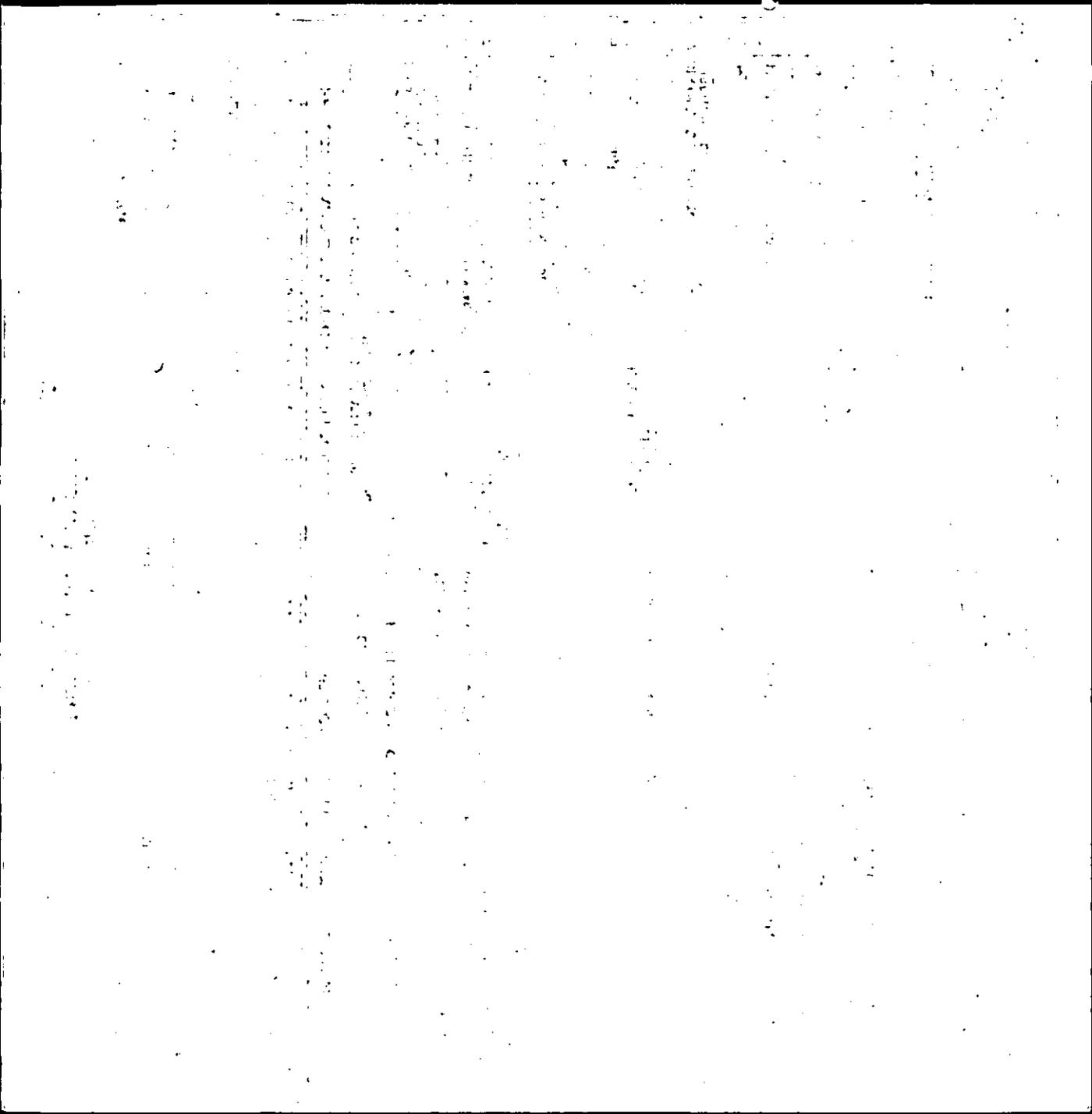
(Signed) Frank Boyd, M. D.

(Address) Summit Mo

OCCUPATION

FATHER

MOTHER



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

ALL INFORMATION ON THIS CERTIFICATE FOR MUST BE WRITTEN IN THIS SPACE

1. PLACE OF DEATH

County Shannon
 Township Emmence
 City (No.)

Registration District No. 824
 Primary Registration District No. 6076

File No. _____
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME William L. Boatman

(a) Residence, No. _____ 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 m
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

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

7. AGE YEARS 76 MONTHS 9 DAYS _____ If LESS than 1 yr., hrs. of _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as 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) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED 11-6- 1935 Frank Heyde MW Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 6 1935

22. HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, last seen _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

General paresis of insane following hemiplegia of aeuric artery of left cerebral hemisphere
Arterio Sclerosis
 Other contributory causes of importance: Arterio Sclerosis

Name of operation _____ Date of _____
 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) Frank Heyde, M. D.
 (Address) Emmence

SUPPLEMENTARY

S-38273