

JUL 31 1937

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

Do not use this space.

24595

1. PLACE OF DEATH

County Platte
Township Calamus
City Payson

Registration District No. 681
Primary Registration District No. 5000A

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

2. FULL NAME

Helcia Beatrice Boon

(a) Residence No. _____ 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 girl 4. COLOR OR RACE black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-5-1937

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 9

8. OCCUPATION OF DECEASED

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

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

PARENTS

10. NAME OF FATHER Simon Boon

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

12. MAIDEN NAME OF MOTHER Helcia Martin

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

14. INFORMANT Simon Boon
(Address) Paysonville Mo

15. FILED June 19 1937 Marshall Jones
REGISTRAR
Paysonville Mo

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14 1937

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1937, to June 14, 1937, that I last saw h. alive on June 13, 1937, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
Premature
10A
10A
(duration) yrs. mos. 9 da.

CONTRIBUTORY (SECONDARY) (duration) 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 (Signed) C. B. D. Smith, M. D. , 19 (Address) Paysonville 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 Clarks ville mo DATE OF BURIAL June 14 1937

20. UNDERTAKER A. B. Boon ADDRESS Paysonville Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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 Pike
Township Calumet
City (No. _____) _____ St. _____ Ward _____

Registration District No. 681
Primary Registration District No. 5909A

File No. 24595-
Registered No. _____

2. FULL NAME

Zelcia Beatrice Boon

(a) Residence, No. _____ St., _____ Ward. _____ (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 girl 4. COLOR OR RACE black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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. 9

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) _____ 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 June 14, 1937 Martha E. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 14, 1937

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h. _____ 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:

Malnutrition
promote

Date of onset

June 5

Other contributory causes of importance: 159

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) C. L. Bankhead, M. D.

(Address) Fayetteville Mo

SUPPLEMENTARY

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

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