

Registration District No. 218

Primary Registration District No. 3015

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Cooper  
(b) City or town Boonville, Mo.  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 93 Yrs. 3 Mo. 21 Days. (Specify whether years, months or days)

8. (a) PRINT FULL NAME Alfred Muir Koontz. 5822

8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Anna MacKenzie Koontz 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 16<sup>th</sup> 1846  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>93</u>	<u>3</u>	<u>21</u>	_____ hr. _____ min.

9. Birthplace Near Boonville Missouri.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Groceryman

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Joseph C. Koontz.

18. Birthplace Shenandoah Co. Virginia.  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Thomas

15. Birthplace Virginia.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature M. J. Koontz

(b) Address Boonville, Mo.

17. (a) Burial (b) Date thereof Jan. 9<sup>th</sup> 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Grove Cem.

18. (a) Signature of funeral director Goodman & Walker

(b) Address Boonville, Mo.

19. (a) 1-8-40 (b) D. J. Cooper  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper  
(c) City or town Boonville  
(If outside city or town limits, write "RURAL")  
(d) Street No. 801 E. Spring St.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 6th.  
year 1940 hour 7 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 4  
\_\_\_\_\_ 1940 to Jan 6, 1940  
that I last saw him alive on Jan 6, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal flu Duration 4 days

Due to acute cold

Due to \_\_\_\_\_

Other conditions Hemorrhage - profuse  
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

28. Signature G. A. Russell (M. D. or other)  
Address Boonville, Mo Date signed 1/8/40

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.

11/2-

RECEIVED  
District Health Officer, No. 8,  
District File Number  
Date Filed 11/2/40

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed G. H. Keller  
Licensed Embalmer No. 3062  
P. O. Address Boonville, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

2165-  
Do not use this space.

1. PLACE OF DEATH

(a) County Cooper Registration District No. 218  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3015 Registered No. \_\_\_\_\_  
 (c) City Boonville (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Alfred Muir Koontz

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.  
93 3 21

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-6-40

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

Intestinal Flu  
acute cold  
Hemorrhage  
 Other contributory causes of importance:  
995 - Hemorrhage principally from trouble - abscess from stomach

Date of onset 4 days

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? clinical Was there an autopsy? no

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) H. A. Russell, M. D.  
 (Address) Boonville mo

SUPPLEMENT

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.

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

