

Registration District No. 733

Primary Registration District No. 4438

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Randolph  
(b) City or town Huntsville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) 7  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 40 yr \_\_\_\_\_ (Specify whether  
years, months or days) 5111

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Randolph  
(c) City or town Huntsville  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME MARY SUSAN BOONE  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb day 17, 1940  
year \_\_\_\_\_ hour 10:00 minute 0 M.

4. Sex F 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed  
6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Mar 10 1868  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mar 1, 1939, to Feb 17, 1940  
that I last saw her alive on Feb 17, 1940  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
71 10 7 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Chronic myocarditis Duration 2 wks  
Due to Arterio-sclerosis & Bright's disease!

9. Birthplace Randolph (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy none

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name Wallace Ray  
13. Birthplace Kentucky (City, town, or county) (State or foreign country)  
14. Maiden name Julia  
15. Birthplace Randolph (City, town, or county) (State or foreign country)

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? 661  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

16. (a) Informant's own signature Mrs Florence Boone  
(b) Address Huntsville Mo

PHYSICIAN  
Underline the cause to which death should be charged statistically.

17. (a) Burial (b) Date thereof Feb 20, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Huntsville Mo

18. (a) Signature of funeral director Tom B. Patton  
(b) Address Huntsville Mo

23. Signature R. V. Ryan M.D. (M. D. or other)  
Address Huntsville Mo Date signed 2/24/40

19. (a) MAR-4-1940 (b) Mrs. D. A. Barnhart  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A FULL STATEMENT OF OCCUPATION IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. 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.

93C

RECEIVED

District Health Officer No. 10

District File Number 3-40-513

Date Filed MAR 5 1940

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 Paul J. Watton

Licensed Embalmer No. 4095

P. O. Address Funksville,

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **7867**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **738**

Primary Registration District No. **4438**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Randolph**  
(b) City or town **Huntsville**  
(If outside city or town limits, write "RURAL" and name of township)  
(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 \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) **PRINCE**  
FULL NAME **Mary Susan Boone**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **wid**

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

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years **71** Months **10** Days **7** If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

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

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **17**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death **arterio sclerosis Bright's Disease (Chronic)**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death) **131**

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

23. Signature **P. J. Dreyer** (M. D. or other) \_\_\_\_\_

Address **Huntsville** \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

