

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **1043**

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

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St. Joseph
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 6313 MORRIS
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution none (Specify whether 2)
 In this community 2 da years, months or days

3. (a) PRINT FULL NAME Shearon Ann Boothe

3. (b) If veteran, name war none 3. (c) Social Security No. none

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased September 24, 1940.
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>2</u>	hr. min.

9. Birthplace St. Joseph, Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business _____

12. Name George Boothe.

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

14. Maiden name Layina Garner

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

16. (a) Informant Thomas Garner

(b) Address 6313 Morris Ave. St. Joseph, Mo.

17. (a) Burial (b) Date thereof Sept. 27, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wallace Cemetery.

18. (a) Signature of funeral director Clark Mortuary

(b) Address 5025 King Hill Ave. St. Joseph, Mo.

19. (a) 9/26/40 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6313 Morris St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26
 year 1940 hour 11 minutes 30 A. M.

21. I hereby certify that I attended the deceased from Sept 24, 1940 to Sept 26, 1940
 that I last saw her alive on Sept 26, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia Duration 1 da

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy: None

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

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 E B Mc Dow (M. D. or other) _____

Address De Kalb Mo Date signed 9/26/40

107W

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 ^{not}.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Eure Clark

Licensed Embalmer No.

3476

P. O. Address.....

S. Joseph 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, fact should be so stated above.

ROWENA MOORE

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 314887

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 1043

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town Joseph
(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 _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Shearon Ann Boothe

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 8

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 _____ Months 2 Days _____ If less than one day _____ hr. _____ 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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.

20. DATE OF DEATH: Month Sept day 26
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: Bronchitis pneumonia
Due to 71. M. 2 #
Due to Physician's cert
off State
Other conditions: _____ (Include pregnancy within 3 months of death)
107a

Major findings: _____
Of operations: _____
Of autopsy: _____
107N

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?
_____ (Specify type of place)
While at work? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTAL

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

