S. No. 2
—11-10-39
. 5-17-39
I X21492

7
1
2

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

FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4459

Registration District No. 796 Primary Registration District No. 3038 Registrar's No. 17

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 360 East Eastwood (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community Fifty years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline 97

(c) City or town Marshall 1 (If outside city or town limits, write "RURAL") 2

(d) Street No. 360 East Eastwood (If rural, give location)

(e) If foreign born, how long in U. S. A.? ✓ years.

3. (a) PRINT FULL NAME Annie Elizabeth Boston

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

4. Sex Female 5. Color or race White 6. (a) ~~Single~~, widowed, ~~married~~, ~~divorced~~ 2 Widowed

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

7. Birth date of deceased March (Month) - 1 (Day) - 1858 (Year)

8. AGE: Years 82 Months 10 Days 17 If less than one day hr. min.

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

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name John McCart
13. Birthplace Dont Know (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Dont Know
15. Birthplace Dont Know (City, town, or county) 9 (State or foreign country)

16. (a) Informant Walter Boston

(b) Address 360 East Eastwood Marshall

17. (a) New Frankfort (Burial, ~~cremation, or removal~~) (b) Date thereof 1-20-41 (Month) (Day) (Year)

(c) Place: burial or cremation New Frankfort Mo

18. (a) Signature of funeral director Jones & Selzer

(b) Address Slater Mo

19. (a) 1-20-41 (Date received local registrar) (b) Mary Kent Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 18 year 1941 hour 28 minute 15 P M.

21. I hereby certify that I attended the deceased from Sept 6th, 1940, to Jan. 3rd, 1941; that I last saw her alive on Jan 3, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocardial Chronic	1 yr
Due to Institutional Nephritis	1 yr
Due to Amyotrophic Lateral Sclerosis	6 mo
Other conditions (Include pregnancy within 3 months of death) Uretero Sclerosis	

Major findings:
Of operations None
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) No

(b) Date of occurrence None

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None (Specify type of place)

While at work? (e) Means of injury

23. Signature Wm E Lockwood (M. D. or other) LD

Address Slater Mo Date signed 1/20/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9-12-41

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 Jas E Jones

Licensed Embalmer No. 3143

P. O. Address Slater 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.