No. 1
1-4-41
-17-39
X28390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

3153

State File No.

FILED JAN 21 1943

Registration District No. 28-7

Primary Registration District No. 4425

Registrar's No. 10

**1. PLACE OF DEATH:**
(a) County Dade
(b) City or town Morrisville
(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 years, months or days)
In this community .....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Missouri (b) County Dade
(c) City or town Morrisville
(If outside city or town limits, write "RURAL")
(d) Street No. .....
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Minerva Eleanor Boaz
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ira Boaz
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased Aug (Month) 15 (Day) 1864 (Year)
8. AGE: Years 78 Months 4 Days 7 If less than one day ..... hr. ..... min.
9. Birthplace Dade County (City, town, or county) Mo (State or foreign country)
10. Usual occupation housewife
11. Industry or business General housekeeping
FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) G (State or foreign country)
MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) G (State or foreign country)
16. (a) Informant .....
(b) Address .....
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation Morrisville Cemetery
18. (a) Signature of funeral director Lucas Bros
(b) Address Greenfield Mo
19. (a) Dec 28 42 (Date received local registrar) (b) Hilland Dickinson (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 22 year 1942 hour 11 minute 20 A.M.
21. I hereby certify that I attended the deceased from June 1942 to June 22 1942 that I last saw her alive on Dec 22 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic interstitial nephritis (Cancer)
Due to Cardio-vascular disease
Due to .....
Other conditions (Include pregnancy within 3 months of death) .....
Major findings: Of operations 1/2/0
Of autopsy .....

Duration

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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature [illegible] (M. D. or other)
Address [illegible] Date signed 12-23-42

633

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 12-42-1447
Date Filed 1-14-43

## 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 Fleeman Bowen

Licensed Embalmer No. 7640

P. O. Address Walnut Grove Mo

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

**If this body is not embalmed, fact should be so stated above.**

. No. 2B
—8-21-41
PI X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 3153

Registration District No. 287 Primary Registration District No. 4420 Registrar's No. 10

1. PLACE OF DEATH:
(a) County: Polk
(b) City or town: Morrisville
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Minerva Eleanor Bong
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: M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Aug (Month) 12 (Day) 1 (Year)

8. AGE: Years 78 Months 4 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name: Samuel Acuff
13. Birthplace (City, town, or county) Tenn (State or foreign country)
14. Maiden name: Anna Scott
15. Birthplace (City, town, or county) Mo (State or foreign country)

16. (a) Informant: Weldon Boyd
(b) Address: Willard Mo.

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

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) Hillard Dickinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 12 year 1942 hour minute M.

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

Immediate cause of death — Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

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

SUPPLEMENTARY