

FILED MAY 4 1943/84
Registration District No. _____

Primary Registration District No. 3038

1. PLACE OF DEATH:
511
(a) County LINN
(b) City or town BROOKFIELD
(If outside city or town limits, write "RURAL" and name of township)
2(c). Name of hospital or institution:
216 W. BOSTON ST
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 4 mos. years, months or days)

3. (a) PRINT FULL NAME NELLIE GRANT BOLEY
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 W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 187 1/2 years

7. Birth date of deceased OCTOBER 31, 1874
(Month) (Day) (Year)

8. AGE: 71 Years 5 Months 12 Days If less than one day _____ hr. _____ min.

9. Birthplace NEAR TINA MO
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE WIFE

11. Industry or business _____

MOTHER FATHER { 12. Name John Penrose
13. Birthplace CARROLL CO. MO
(City, town, or county) (State or foreign country)
14. Maiden name ELIZABETH DUNN
15. Birthplace CARROLL CO. MO
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Barney Boley
(b) Address BROOKFIELD, MO.

17. (a) BURIAL (b) Date thereof APR. 15, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HURRICANE CEM, HALE, MO

18. (a) Signature of funeral director Rusk Funeral Home
(b) Address BROOKFIELD, MO.

19. (a) 4-14-43 (b) J. W. Cannon
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 11
(a) State MISSOURI (b) County CARROLL
(c) City or town HALE
(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. 1 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 13
year 1943 hour 10 minute 00 A. M.

21. I hereby certify that I attended the deceased from March 2, 1943, to April 13, 1943; that I last saw her alive on April 12, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death uremia

Due to acute myocarditis 2 mo.

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
Of operations _____
Of autopsy _____

Duration 2 mo.
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 Dr. H. W. Poth (M. D. or other) D.O.
Address Masonic Bldg. Brookfield Mo. Date signed 4-14-43

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1943-1

1014 103

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..... *H. B. Wright*

Licensed Embalmer No. *3718*

P. O. Address..... *Brookfield, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 14751
Registrar's No. 175

Registration District No. 184

Primary Registration District No. 3038

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(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 4 mo. years, months or days

3. (a) PRINT FULL NAME Nellie G. Boley

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced w

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

7. Birth date of deceased. Oct. 31 (Month) (Day) (Year)

8. AGE: Years 71 Months 5 Days 1 (If less than one day) min.

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER { 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 Mo. (b) County Carroll
(c) City or town Hale (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day _____ year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia (acute) Duration 2 mo

Due to Acute myocarditis 2 mo

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)

(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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY 3

S-141751