S. No. 2
M—5-42
y. 5-17-39

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31149

FILED OCT 11 1943

Registration District No. 3 8 — Primary Registration District No. 006-520 — Registrar's No. 215

1. PLACE OF DEATH:
(a) County: Boone
(b) City or town: Columbia (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ellis Fischel State Cancer (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: 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Camden
(c) City or town: Lucasville (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: Boan Fieldon
3. (b) If veteran, name war: ..... 3. (c) Social Security No. .....
4. Sex: M 5. Color or race: W 6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Mandy Boan 6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: October (Month) 11 (Day) 1870 (Year)

8. AGE: Years 72 Months 11 Days 3 If less than one day ..... hr. ..... min.

9. Birthplace: Miller County Mo. (City, town, or county) (State or foreign country)
10. Usual occupation: Laborer
11. Industry or business: .....
FATHER 12. Name: William Boan
FATHER 13. Birthplace: ..... Illinois (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Melander Simpson
MOTHER 15. Birthplace: ..... Illinois (City, town, or county) (State or foreign country)
16. (a) Informant: Patient
(b) Address: Lucasville
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-14-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Lebanon Mo
18. (a) Signature of funeral director: S. R. Palmer
(b) Address: Lebanon Mo
19. (a) 9/14 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 14 year 1943 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from Sept 9 to Sept 14, 1943 to ....., 19..... ; that I last saw him alive on Sept 14, 19..... ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia	1 week
Due to: Carcinoma of Prostate	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

51 f

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): —
(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: H. M. Wiley D. (M. D. or other)
Address: Columbia, Mo. Date signed 9-19-43

(Licensed Embalmer's Statement on Reverse Side)

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.....S. R. Palmer.....

Licensed Embalmer No.....2208.....

P. O. Address.....Lebanon 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.