

No. 2  
I-2-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 348

FILED DEC 17 1943  
Registration District No. 207

Primary Registration District No. 3043

Registrar's No. 348

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

1. PLACE OF DEATH:

(a) County Marion

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

(c) Name of hospital or institution: Levering Hosp.  
(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

(c) City or town Hannibal  
(If outside city or town limits, write "RURAL")

(d) Street No. 818 Union  
(If rural, give location)

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

3. (a) PRINT FULL NAME Anthony Arthur Bozarth

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

4. Sex Male 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 November 5, 1943  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
			<u>3</u>	hr. _____ min.

9. Birthplace Hannibal Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation XX

11. Industry or business XX

MOTHER FATHER { 12. Name Kenneth E. Bozarth

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

14. Maiden name Mildred C. Howell

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

16. (a) Informant Kenneth E. Bozarth  
(b) Address 818 Union Hannibal Mo

17. (a) Burial (b) Date thereof 11/9/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olivet

18. (a) Signature of funeral director Wm M Smith  
(b) Address 902 Broadway Hannibal Mo

19. (a) Nov 13 '43 (b) R M Connor  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 8  
year 1943 hour 9 minute 05 A. M.

21. I hereby certify that I attended the deceased from 11-5-43  
to 11-8-43, 19\_\_\_\_  
that I last saw him alive on 11-8-43, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Injury

Due to Preexisting Ocular active labor not over 30 minutes

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 1600

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 J E Sultman (M. D. or other) 11/8/43  
Address Hannibal Mo Date signed 11/8/43

Duration 3 Days

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

**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.....

George T. Bond

, Registered Apprentice No. 350

working under my personal supervision.

Signed.....

*Wm. M. Smith*

Licensed Embalmer No. 1204

P. O. Address..... Hannibal Missouri

**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.**