V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43632

FILED JAN 10 1944

Registration District No. _____ Primary Registration District No. 3063 Registrar's No. 2999

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1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Clayton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Louis Col Hospt. (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 49 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County ST. LOUIS
(c) City or town Brentwood (If outside city or town limits, write "RURAL") /
(d) Street No. 8705 Agnes (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) /
If yes, name country _____

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3. (a) PRINT FULL NAME MOSES BOATWRIGHT
3. (b) If veteran, name war WORLDWAR #1
3. (c) Social Security No. _____
4. Sex M.
5. Color or race C
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife ORA BOATWRIGHT
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased SEPT. (Month) 1 (Day) 1892 (Year)

8. AGE: Years 51 Months 3 Days 30 If less than one day _____ hr. _____ min.

9. Birthplace Miss. (City, town, or county) / (State or foreign country)
10. Usual occupation Laborer
11. Industry or business Wagon Factory
MOTHER FATHER
12. Name Moses Boatwright
13. Birthplace Miss. (City, town, or county) / (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown (City, town, or county) / (State or foreign country)
16. (a) Informant Mrs Bertha Ora Boatwright
(b) Address ~~8140 Bell Ave~~ 8705 Agnes
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 5 44 (Month) (Day) (Year)
(c) Place: burial or cremation Mount Cemetery
18. (a) Signature of funeral director A. T. Walton
(b) Address 2707 Stoddard
19. (a) JAN 6 1944 (Date received local registrar) (b) E. D. McGavran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 31 year 44 hour _____ minute 4 30A M.
21. I hereby certify that I attended the deceased from 12/17, 1943 to 12-31, 1943 that I last saw him alive on 12-30-43, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia — Duration
Due to Bronchial Pneumonia
Due to _____
Other conditions None (Include pregnancy within 3 months of death)
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) None
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (City or town) (County) (State) (Specify type of place)
While at work? None (e) Means of injury None
23. Signature A. J. Doignelly (M.D. or other)
Address 4 Clayton Shores Date signed 1/2/44

(Licensed Embalmer's Statement on Reverse Side)

FEB 3 1944

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.....

Licensed Embalmer No. 3522

P. O. Address.....

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.