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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 11 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3994**
Registrar's No. **16**

Registration District No. **290**

Primary Registration District No. **4430**

1. PLACE OF DEATH:

(a) County **Pulaski**
(b) City or town **Crocker, Mo.**
(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 **Life**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Pulaski**
(c) City or town **Crocker,**
(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 **Carolyn Kay Boulware**

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

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **0**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Nov. 11, 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 2 20 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name **Melvin Boulware**
13. Birthplace **Dixon, Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Ina Lewis**
15. Birthplace **Black, Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Melvin Boulware**
(b) Address **Crocker, Mo.**

17. (a) **Burial** (b) Date thereof **2/2/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Crocker Cem.**

18. (a) Signature of funeral director **J. L. Hoops & Sons**
(b) Address **Crocker, Mo.**

19. (a) **Feb 5-1944** (b) **Chas M. G. [Signature]**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **1st**
year **1944** hour **11** minute _____ a.m.

21. I hereby certify that I attended the deceased from **Jan. 31st**
1944 to **Feb. 1, 1944**
that I last saw him alive on **Feb. 1, 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia, bronchial**
Influenza
Infection
Duration **1 day 5 days**

Other conditions **330**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy **not made**
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 **C. J. Waller** (M. D. or other)
Address **Crocker, Mo.** Date signed **2-3-44**

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

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 *Paul B. Hoops*

Licensed Embalmer No. *3261*

P. O. Address *Grocher, 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.