

FILED JUN 20 1944

Registration District No. **42**

Primary Registration District No. **5142**

Registrar's No. **157**

1. PLACE OF DEATH:

(a) County **Butler**
 (b) City or town **rural Mellyville** (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **rural**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **28 years** (Specify whether years, months or days)
 In this community **28 years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Butler**
 (c) City or town **Mellyville** (If outside city or town limits, write "RURAL")
 (d) Street No. **rural** (If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country **0**

3. (a) PRINT FULL NAME

James H. Boor

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

4. Sex **0 male** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **2 widowed**
 6. (c) Age of husband or wife if alive **14** years (Day) (Year)
 7. Birth date of deceased **June 14, 1857** (Month) (Day) (Year)

8. AGE: Years **96** Months **11** Days **8** If less than one day hr. min.

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

10. Usual occupation **farming**

11. Industry or business

MOTHER FATHER { 12. Name **Joseph Boor**
 13. Birthplace **Ohio** (City, town, or county) (State or foreign country)
 14. Maiden name **Lucy Ann Green**
 15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **2119 1/2 N. with K. C. Karsay**

(b) Address **H. G. Boor**

17. (a) **Burial** (b) Date thereof **May 10, 1944** (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Woodlawn Cem.**

18. (a) Signature of funeral director **Blackie Montroy**

(b) Address **Carroll Ave**

19. (a) **5-12-44** (b) **Belle Karsay** (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **7** year **1944** hour **1** minute **P.M.**
 21. I hereby certify that I attended the deceased from **May 1** to **May 7**, 19 **44**
 that I last saw him alive on **May 2**, 19 **44**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombi** Duration

Due to **94a**
 Due to **Severely**

Other conditions **Severely** (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? _____

(Specify type of place) While at work? _____ (e) Means of injury _____

23. Signature **J. J. Farr** (M. D. or other) _____
 Address **Mellyville** Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK

RECEIVED

District Health Office No.

District File Number 644-7

Date Filed 6-8-44

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 Leslie D. Russell

Licensed Embalmer No. 3855

P. O. Address Cornig Ark.

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.