

No. 2  
8-43  
17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED OCT 25 1944**  
Registration District No. ....

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**  
Primary Registration District No. 3016

State File No. 34943  
Registrar's No. 227

1. PLACE OF DEATH:  
(a) County Cole  
(b) City or town Jefferson City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Prison  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community 6 months  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Cole  
(c) City or town Jefferson City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 513 E. Capitol Ave.  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Clery Aodyne Boone  
3. (b) If veteran, name war No.  
3. (c) Social Security No. 486-16-6285

20. DATE OF DEATH: Month Oct day 19  
year 1944 hour 7 PM minute..... M.

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

21. I hereby certify that I attended the deceased from no attendance, 19...  
that I last saw h..... alive on....., 19...  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

7. Birth date of deceased Not Known  
(Month) (Day) (Year)  
8. AGE: Years 57 Months Days If less than one day  
hr. min.

Duration  
Heart Disease  
Due to.....  
Due to.....

9. Birthplace Brushy, Mo. Adair Co.  
(City, town, or county) (State or foreign country)  
10. Usual occupation.....  
11. Industry or business.....

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
Other conditions.....  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations.....  
Of autopsy.....

MOTHER, FATHER { 12. Name H. S. Boone  
13. Birthplace Adair Co. Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Aodyne Boone  
15. Birthplace Adair Co. Mo.  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.  
22. If death was due to external causes, fill in the following:  
(c) 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.....

16. (a) Informant H. S. Boone  
(b) Address Gibbs Mo.  
17. (a) Burial Date thereof 10-16-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Gibbs Cemetery  
Adair Co.  
18. (a) Signature of funeral director Victor Buescher  
(b) Address Jefferson City, Mo.  
19. (a) 10-14-44 (b) Therma Richter  
(Date received local registrar) (Registrar's signature)

23. Signature Edw. Maurer (M.D. or other)  
Address Jefferson City, Mo.  
10-14-44  
Carl Over

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

NOV 3 1944

RECEIVED

District Health Officer No. 9

District File Number 10-444

Date Filed 10-23-44

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 Victor Buescher

Licensed Embalmer No. 3701

P. O. Address Jefferson City

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 227

1. PLACE OF DEATH:

(a) County cole  
(b) City or town Jefferson city  
(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 \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Elsery O. Boone  
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 5  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)

8. AGE: Years 57 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 Day 23  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death Heart disease Duration \_\_\_\_\_

Due to Coronary thrombosis probably  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
5.123MED

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTAL

34043