

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41932**

FILED JAN 15 1945
Registration District No. **5998**

Primary Registration District No. **5998**

Registrar's No. **91**

1. PLACE OF DEATH:

(a) County **Putnam**
(b) City or town **Rural - York**
(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:
In this community **All His Life**
years, months or days

3. (a) PRINT FULL NAME **John S. Boland**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Kittie Boland** 6. (c) Age of husband or wife if alive **69** years
7. Birth date of deceased **Jan. 11 1865**
(Month) (Day) (Year)

8. AGE: Years **79** Months **11** Days **10** If less than one day
hr. **28** min.

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

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER { 12. Name **John Boland**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Margaret Johnson**
15. Birthplace **Sullivan Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. John Boland**
(b) Address **Powersville, Mo.**

17. (a) **Burial** (b) Date thereof **12-28-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Lucerne Mo. Cem**

18. (a) Signature of funeral director **Martin Funeral Home**
(b) Address **Princeton, Mo.**

19. (a) **12/23/44** (b) **[Signature]**
(Date received local report) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Putnam**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **N.W. Lucerne, Mo.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **21**
year **1944** hour **12** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Dec 1**
1942 to **Dec 21**, 19**44**
that I last saw him alive on **Dec 21**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death

Cardiac failure
Coronary thrombosis

Other conditions
(Include pregnancy within 3 months of death)

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) (c) Means of injury
23. Signature **G. A. Dale** (M. D. or other)
Address **Newtown Mo** Date signed **12/21/44**

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

FEB 8 1945

RECEIVED

District Health Officer No. 10

District File Number 1-45-145

Date Filed JAN 12 1945

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. 3760

P. O. Address. Shenandoah, 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.