

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 94

FILED MAR 15 1945

Registration District No. _____ Primary Registration District No. 5418

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Boone Gap
(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 years, months or days)

In this community 73 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Franklin

(c) City or town Herald Mo Rural
(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 William T Boston

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 11 year 1945 hour 4 PM minute _____ M.

21. I hereby certify that I attended the deceased from April 1944 to Feb 11 1945 that I last saw him alive on Feb 4 1945 and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lou Boston 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 30 (Month) (Day) 1870 (Year)

Immediate cause of death Berger's Disease (arteritis)

Due to _____

Due to _____

Other conditions Pulmonary T.B.?
(Include pregnancy within 3 months of death)

8. AGE: Years 74 Months 9 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation farmer

11. Industry or business _____

12. Name Josiaway Boston

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

14. Maiden name Emily Fitzgerald

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

16. (a) Informant Ray T Boston

(b) Address Washington Mo

17. (a) Burial (b) Date thereof 2 14 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Herald Prot. C.

18. (a) Signature of funeral director E J Meyer

(b) Address Herald Mo

19. (a) 2/12/45 (b) Herald
(Date received local registrar) (Registrar's signature)

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) Means of injury _____

23. Signature Charles A Schmidt (M. D. or _____)

Address Herald Mo Date signed 2-13-45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 3-14-45

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 me.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Robert M Murray

Licensed Embalmer No. 3749

P. O. Address Quincyville, 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.