S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 31 1945

State File No. 23929

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 540

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: residence of 1345 West. Bennett (Mrs. Marie Collins) (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3½ Months. (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene 39

(c) City or town Strafford (If outside city or town limits, write "RURAL")

(d) Street No. R.7 (If rural, give location)

(e) Citizen of foreign country? X (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Calvin Boland

3. (b) If veteran, name war No

3. (c) Social Security No. unk.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Sarah Boland

6. (c) Age of husband or wife if alive unk. years

7. Birth date of deceased Feb. (Month) 6, (Day) 1870 (Year)

8. AGE: Years 75 Months 5 Days 2 If less than one day hr. min.

9. Birthplace Unk. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Boyd M. Boland

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

MOTHER 14. Maiden name Unknown

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

16. (a) Informant Alfred Boland

(b) Address Strafford, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-45 (Month) (Day) (Year)

(c) Place: burial or cremation Marshfield, Mo.

18. (a) Signature of funeral director Ray Ramey

(b) Address Marshfield Mo

19. (a) 7-9-45 (Date received local registrar) (b) S. M. Hardy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8th year 1945 hour 1:00 minute A. M.

21. I hereby certify that I attended the deceased from no physician, 19..., to attendance, 19...; that I last saw him alive on, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary occlusion	
Due to: Arterio sclerosis	
Due to:	
Other conditions: Chronic myocarditis (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy as above

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 Tommy C. Stone Coroner (M. D. or other)

Address Springfield, Mo. Date signed 7-8-45

984

(Licensed Embalmer's Statement on Reverse Side)

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 Rex Rainey

Licensed Embalmer No. 3312

P. O. Address Marshfield 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.