

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12207**

FILED MAY 8 1946

Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **512**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 Days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Holt** **44**
(c) City or town **New Point (Hickory Township)** **0**
(If outside city or town limits, write "RURAL")
(d) Street No. **0**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No) **1**
If yes, name country _____

3. (a) PRINT FULL NAME

Spencer G. Boswell

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Polly Ellen Boswell** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April 1860**
(Month) (Day) (Year)

8. AGE: Years **86** Months **0** Days **26** If less than one day
hr. _____ min. _____

9. Birthplace **New Point Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business _____

12. Name **John Boswell**

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

14. Maiden name **Mary Hudson**

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

16. (a) Informant **Strother Boswell**

(b) Address **New Point, Missouri**

17. (a) **Burial** (b) Date thereof **May 1 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Point, Missouri**

18. (c) Signature of funeral director **James H. Pettigrew**

(b) Address **Oregon, Mo.**

19. (a) **May 3, 1946** (b) **W. H. Nestlebusch**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **30**
year **1946** hour **3** minute **30** A. M.

21. I hereby certify that I attended the deceased from **April 14 1946** to **April 30 1946**
that I last saw him alive on **Apr 29 1946**
and that death occurred on the date and hour stated above.

Immediate cause of death **Aspirin poisoning General Aspirin toxic heart and kidney disease**

Due to **Hypertrophy of frontal Uremia**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration _____
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. H. Linton** (M. D. or other) **M.D.**
Address **St. Joseph Mo** Date signed **5-1-46**

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

MOTHER, FATHER

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.....

James H. Pittijohn

Licensed Embalmer No. *3192*

P. O. Address..... *Oregon 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.