

## FILED APR 17 1946 STANDARD CERTIFICATE OF DEATH

State File No. 13736

Registration District No. 175

Primary Registration District No. 5648

Registrar's No. 30

## 1. PLACE OF DEATH:

(a) County Lawrence  
 (b) City or town Rural - Mt. Pleasant  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Wentworth Rt. # 1.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 Months  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sherrel Frances Boggs3. (b) If veteran, name war none 3. (c) Social Security No. none4. Sex Female 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

7. Birth date of deceased January 9, 1946  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
-- 2 13 hr. min.9. Birthplace Lawrence Co., Missouri  
(City, town, or county) (State or foreign country)

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

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

12. Name Charles Boggs13. Birthplace Lawrence Co., Missouri  
(City, town, or county) (State or foreign country)14. Maiden name Veneta Overall15. Birthplace Newton Co., Missouri  
(City, town, or county) (State or foreign country)16. (a) Informant Mr. Charles Boggs(b) Address Rt # 1, Wentworth, Mo.17. (a) Burial (b) Date thereof 3-24-46  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Sarcoxie Cemetery18. (a) Signature of funeral director Ed. C. Ulmer(b) Address Carthage, Missouri19. (a) 3-25-1946 (b) Dora Mc matt  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence  
 (c) City or town Rural - Rt. # 1, Wentworth  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Rt # 1, Wentworth  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22  
year 1946 hour 1:30 minute a.m.21. I hereby certify that I attended the deceased from March 16  
1946 to March 22, 1946  
that I last saw her alive on March 21, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Pulmonary Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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

Of autopsy \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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)  
(d) Means of injury \_\_\_\_\_23. Signature Kenneth Hoover (M.D. signature)Address Wentworth, MO Date signed 3-23-46

RECEIVED

District Health Officer No. 6,

District File Number 446-451

Date Filed APR 15 1946

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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

*John S. Pennehy*

Licensed Embalmer No. 4198

P. O. Address Carthage 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.**

State File No. May  
Registrar's No. 301

Registration District No. 175

Primary Registration District No. 5648

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Rural  
(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 Sherrel F Boggs

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Jan 9 (Month) (Day) (Year)

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

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

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 May year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

Bronchial Pneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

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

Of autopsy 107

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 Levith Glover MD (M. D. or other) \_\_\_\_\_

Address Lawrence, Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

12640

SUPPLEMENTARY

13736