

S. No. 2
DM-5-43
v. 5-17-39
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23273

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 619

Registration District No. 128 Primary Registration District No. 2000

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:
633 S. Broadway
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 633 S. Broadway
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Elmer E. Boggs
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 Widower
6. (b) Name of husband or wife UNK
6. (c) Age of husband or wife if alive Dec. years
7. Birth date of deceased May 26, 1861
(Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days 27
If less than one day _____ hr. _____ min.

9. Birthplace Centralia Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER {
12. Name Ellsworth Boggs
13. Birthplace UNK UNK
(City, town, or county) (State or foreign country)
14. Maiden name Martha Telford
15. Birthplace UNK UNK
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Robert Mack Sr.
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof 7-25-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Lawn Cem.

18. (a) Signature of funeral director UNK
(b) Address Springfield, Mo.

19. (a) 7-23-46 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 23
year 1946 hour 12 minute 15 A. M.
21. I hereby certify that I attended the deceased from July 22
1946, to _____, 19____;
that I last saw him alive on July 22 only, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Bronchitis, acute / 1 wk
Due to Senility
Due to _____
Other conditions none
(Include pregnancy within 3 months of death)

Major findings: none
Of operations none
Of autopsy none
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?
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature Don H. Sulahy (M. D. or other) M.D.
Address Springfield, Mo. Date signed 7-23-46

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

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6/23/46

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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 *Ray A. Slavins*

Licensed Embalmer No. *1763*

P. O. Address *Springfield 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.