

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED SEP 6 1946 STANDARD CERTIFICATE OF DEATH

26554

State File No. _____

Registrar's No. 32

Registration District No. 2

Primary Registration District No. 5239

1. PLACE OF DEATH:

(a) County Cedar
(b) City or town Rural--Linn Township
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
XXXXXXXXXX
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution XXXXXXXX
(Specify whether
In this community Most of life
years, months or days)

3. (a) PRINT FULL NAME THOMAS JACKSON BOUGH

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Bertha Bough 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased April 27, 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 3 27 XXX hr. XXX min.

9. Birthplace XX Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business XXXXXXXXXX

MOTHER FATHER { 12. Name Fred Bough
13. Birthplace XXX Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Sintha Clark
15. Birthplace XXX Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Bertha Bough
(b) Address Stockton, Missouri

17. (a) Burial (b) Date thereof 8-18-1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Caplinger Mills, Mo.

18. (a) Signature of funeral director CHURCH AND NEALE
(b) Address Stockton, Missouri

19. (a) Aug 20-46 (b) Genevieve Garrison
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Linn Township
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country XXXXXXXXXX

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 17
year 1946 hour 7 minute P. M.

21. I hereby certify that I attended the deceased from 5-25, 1946, to 8-16, 1946.
that I last saw him alive on 8-16, 1946.
and that death occurred on the date and hour stated above.

Immediate cause of death Undetermined Duration 3 da.

Due to: Arteriosclerotic
hypertensive heart yrs.
hypertrophy prostate yrs.
Renal Calculi yrs.
Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations 134A
Of autopsy _____
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) (d) Means of injury _____
23. Signature Wm B. Richter (M, D, or other) D
Address Stockton Mo. Date signed 8-19-46

54 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Office
District File No. 8-46-920
Date Filed 9-3-46

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.....

Licensed Embalmer No.....

P. O. Address.....

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.