

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

29671
State File No.

320
Registrar's No.

FILED SEP 30 1946

Registration District No.

Primary Registration District No.

3007

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

1. PLACE OF DEATH:

(a) County. Butler
(b) City or town. Caplan Bluff
(c) Name of hospital or institution: 18
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 10 days
(Specify whether
In this community. 10 days
years, months or days)

3. (a) PRINT
FULL NAME

JOHN EARL BONE

3. (b) If veteran,

name war.

3. (c) Social Security

No.

4. Sex.

MO

5. Color or

race

W

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

6. (b) Name of husband or wife

Nessie

6. (c) Age of husband or wife if

alive 32 years

7. Birth date of deceased

Dec

1900

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

45

9

18

hr.

min.

9. Birthplace

Carle Co Mo

(City, town, or county)

(State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Jones Bone

13. Birthplace

Gro Co Mo

(City, town, or county)

(State or foreign country)

14. Maiden name

Walter Haskins

15. Birthplace

Carle Co Mo

(City, town, or county)

(State or foreign country)

16. (a) Informant

Clay Harris

(b) Address

Van Buren Mo

17. (a)

Funeral

(b) Date thereof

9-20-46

(Burial, cremation, or removal)

(Month)

(Day)

(Year)

(c) Place: burial or cremation

Brown Cemetery

18. (a) Signature of funeral director

Walter Haskins

(b) Address

Van Buren Mo

19. (a)

9/22/46

(b)

Walter Haskins

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Mo (b) County. Carter 18
(c) City or town. Rural 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. (If rural, give location) 1
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19
year 1946 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from

1 Sept 6 1946 to Sept 19 1946

that I last saw him alive on Sept 19 1946
and that death occurred on the date and hour stated above.

Immediate cause of death

Generalized peritonitis

Duration

Due to ruptured gangrenous appendix

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations ruptured gangrenous appendix

Of autopsy same

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) no

(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 Walter Haskins (M. D. or other)

Address Caplan Bluff Date signed 9-22-46

RECEIVED

District Health Office No. 2,

District File Number 1046-1183

Date Filed 10-1-46

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 9-19-4

....., Registered Apprentice No.
working under my personal supervision.

Signed Philip A. Senchel

Licensed Embalmer No. 2936

P. O. Address Van Buren

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.