

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

1. PLACE OF DEATH:

(a) County Shelby County
(b) City or town Shelbyville, Mo
(c) Name of hospital or institution County Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 years
In this community Entire life
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert P. Boling

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife None

6. (c) Age of husband or wife if alive X years

7. Birth date of deceased October 21st 1863
(Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days 11
If less than one day hr. min.

9. Birthplace Shelby county Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER { 12. Name John Boling
13. Birthplace Kentucky
14. Maiden name Luella Johnson
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence Boling
(b) Address Shelbina, Mo.

17. (a) Burial (b) Date thereof 10-4-1946
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Ridge Cemetery

18. (a) Signature of funeral director Million & Barkelew
(b) Address Shelbina Missouri

19. (a) Oct 29 46 (b) Ruth Joyner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby
(c) City or town Shelbina, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month October day 2nd
year 1946 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 2 July 30 1946 to Oct 2 1946
that I last saw him alive on Oct 1 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis ?

Duration _____

Due to _____

Due to _____

Other conditions Beginning gangrene
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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) (e) Means of injury _____

23. Signature P. C. Anderson (M. D. Anderson)
Address Shelbina, Mo Date signed 10-5-46

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. 3498

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.

RECEIVED
District Health Officer No. 10
District File No. 10-46-2023
Date Filed NOV 8 1946