

FILED FEB 17 1947
Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **197**

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 yrs. 11 mos. 22 days
(Specify whether years, months or days) most of life
In this community most of life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 228 W. Chestnut St. St. Joseph, Mo.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME DAVID BOATWRIGHT

3. (b) If veteran, name war _____ 3. (c) Social Security 487-09-1538

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife not stated Bessie 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 2-22-1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 11 12 hr. min.

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

10. Usual occupation Stationary Engineer

11. Industry or business Engineer

MOTHER FATHER

12. Name James P. Boatwright

13. Birthplace Hartley Missouri
(City or town or county) (State or foreign country)

14. Maiden name Frances M. Jennings

15. Birthplace Somersett Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bessie Boatwright
(b) Address 228 W. Chestnut St. St. Joseph, Mo.

17. (a) Burial (b) Date thereof Feb. 6, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jennings Cemetery
St. Joseph, Mo.

18. (a) Signature of funeral director E. D. Johnson
(b) Address 607 South 10th St.

19. (a) 2-12-47 (b) H. C. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 4
year 1947 hour 4 minute 05 A.M.

21. I hereby certify that I attended the deceased from 4-17- 1944 to 2-4- 1947
that I last saw him alive on 2-3- 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration 3 days

Due to arterio-sclerosis 20 years

Due to Bacteremia 8 days

Other conditions gangrene of Right foot 9 days
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: AM
Of operations _____
Of autopsy _____
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 D

23. Signature J. H. Warron (M. D. _____)
Address State Hospital No. 2 Date signed 2-4-47

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

FEB 20 1947

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

Mollie E. Sidenfaden Fox

Licensed Embalmer No.

4235

P. O. Address

St. Joseph, 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.