

No. 2  
8-43  
5-17-59  
X37823

FILED MAR 11 1947

State File No. \_\_\_\_\_

Registration District No. 103

Primary Registration District No. 4-KT

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Dunklin

(b) City or town Arboret Mo. R. 1  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(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 Dunklin <sup>35</sup>

(c) City or town Arboret <sup>0</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location) <sup>0</sup>

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME FRANK MILTON LUIS BOONE

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17  
year 1947 hour 5 minute 0 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death: Asphyxiation

Duration \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 23 1946  
(Month) (Day) (Year)

Due to Suffocation

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day

4 24 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Larance Michigan  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Ray Boone

13. Birthplace Palstene Ark  
(City, town, or county) (State or foreign country)

14. Maiden name Garne Hubert

15. Birthplace Lyan France  
(City, town, or county) (State or foreign country)

16. (a) Informant Ray C Boone

(b) Address Arboret Mo R 1 c/o Claude Magee

17. (a) \_\_\_\_\_ (b) Date thereof 2/18-1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Catholic Church

18. (a) Signature of funeral director W. T. Emerson

(b) Address Daneshoro Ark

19. (a) 2-17-47 (b) Bertha King  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Reineth \_\_\_\_\_ or other \_\_\_\_\_  
Address Mo Date signed 2-5-47

ADDITIONAL PHYSICIAN SUPPLEMENTARY INFORMATION REQUIRED the cause of death should be stated statistically.

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

MOTHER FATHER

RECEIVED

Lic. No. \_\_\_\_\_

District No. 347-33

Date Filed 3-19-47

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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.....

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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. MarchRegistration District No. 105Primary Registration District No. 5417Registrar's No. 7

## 1. PLACE OF DEATH:

(a) County Dunklin  
 (b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
(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) (Specify whether

3. (a) PRINT FULL NAME Franklin Beone

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced s

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased Sept 23 1912  
(Month) (Day) (Year)8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Day \_\_\_\_\_ (if less than one day)  
 hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Mich  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace Mich  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

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

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb 1947  
 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 162  
(Include pregnancy within 6 months of death)Major findings: 16  
 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) Accident(b) Date of occurrence Feb 17th 1947(c) Where did injury occur? Arbyrd Dunklin Mo  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
at home while at sleep

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Walter A. Hays (M.D. or other)Address Arbyrd Mo Date signed \_\_\_\_\_

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

S-4463