

S. No. 2
4-8-43
5-17-39
PI X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12330

State File No. _____

Registration District No. _____

Primary Registration District No. **5004**

Registrar's No. **122**

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

1. PLACE OF DEATH:
(a) County **Adair County**
(b) City or town **Novinger, Mo.**
(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 **3 yr.** years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Adair**
(c) City or town **Novinger**
(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 _____

3. (a) PRINT FULL NAME **William Oliver Bozarth**

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

4. Sex **M O** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M /**

6. (b) Name of husband or wife **Jennie Elizabeth** 6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **Sept 11, 1855**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
91 6 5 hr. min.

9. Birthplace **Adair Co., Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business _____

12. Name **James Madison Bozarth**

13. Birthplace **Adair County Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Rachel McPhetridge**

15. Birthplace **Adair County Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Jennie E. Bozarth**
(b) Address **Novinger, Mo.**

17. (a) **Burial** (b) Date thereof **Mar 13, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Greencastle, Mo.**

18. (a) Signature of funeral director **Blum & Co. Inc.**
(b) Address **Green City, Mo.**

19. (a) **4-19-47** (b) **Wate Lambert**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **16**
year **1947** hour **12:15** minute **0** M.

21. I hereby certify that I attended the deceased from **1947** to **March 1, 1947**
that I last saw him alive on **March 12**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Volvular Heart Disease**

Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: **A3D**
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following: "
(c) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

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 **J. P. Garrison** (M.D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 10
District File Number 4-47-738
Date Filed APR 28 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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Purdin, 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.