

No. 2
15-42
17-30
192873

FILED SEP 15 1947

Registration District No. **3353**

Primary Registration District No. **6196**

Registrar's No. **14**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Rural Sherell**
(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 **45 years** years, months or days) (Specify whether

3. (a) PRINT FULL NAME **DE BOREN**

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 **Harriet Boren** 6. (c) Age of husband or wife if alive **66** years

7. Birth date of deceased (Month) **Oct** (Day) **20** (Year) **1873**

8. AGE: Years **74** Months **9** Days **21** If less than one day hr. min.

9. Birthplace (City, town, or county) **not known** (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business _____

12. Name **Henry Boren**

13. Birthplace (City, town, or county) **not known** (State or foreign country)

14. Maiden name **not known**

15. Birthplace (City, town, or county) **not known** (State or foreign country)

16. (a) Informant **Harriet Boren**

(b) Address **Licking Mo.**

17. (a) (Burial, cremation, or removal) **Burial** (b) Date thereof (Month) **Feb** (Day) **13** (Year) **47**

(c) Place: burial or cremation **Licking Mo.**

18. (a) Signature of funeral director **W. M. Ferguson**

(b) Address **Licking Mo.**

19. (a) **8-13-47** (Date received local registrar) (b) **Edmura Nese** (Registrar's signature) **5.3 P**

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Texas**
(c) City or town **Rural Licking Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **1 1/2 mi west of Licking Mo.**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **11** year **1947** hour **8** minute **—** P. M.

21. I hereby certify that I attended the deceased from **Feb** 19 **46** to **Aug 9** 19 **47** that I last saw him alive on **Aug 9** 19 **47** and that death occurred on the date and hour stated above.

Immediate cause of death **myocarditis**

Due to **pus prostate**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **1947**

Of autopsy _____

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 place of place) (e) Means of injury _____

23. Signature **W. M. Ferguson** M. D. or other _____

Address **Licking Mo.** Date signed **8/12/47**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District

947491
9-12-47

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 Robert Ferguson
Licensed Embalmer No. 3945
P. O. Address Rocking Md

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Sept 19*

Registration District No. *353*

Primary Registration District No. *6196*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Texas*
(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)

3. (a) PRINT FULL NAME *De Bolen*

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

4. Sex *m* race *w* 5. Color or _____
6. (a) Single, widowed, married, divorced *m*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *Oct 20* (Month) *19* (Day) _____ (Year)

8. AGE: Years *74* Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 _____ day _____
year *1947* hour _____ minute _____ 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.

Duration _____

Due to _____
Due to _____

Other conditions _____ (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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

5-30118