S. No. 2
M—1/47
r. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31681

FILED OCT 9 1947

Registration District No. ____ Primary Registration District No. 3033 Registrar's No. ____

1. PLACE OF DEATH
(a) County: Laclede
(b) City or town: Lebanon (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 10 days (Specify whether years, months or days) In this community: 24 yrs.

2. USUAL RESIDENCE OF DEATH:
(a) State: Mo (b) County: Laclede
(c) City or town: Lebanon Mo (If outside city or town limits, write "RURAL")
(d) Street No.: Laclede Hotel (If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

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3. (a) PRINT FULL NAME: Walter C. Booth
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: Divorced
6. (b) Name of husband or wife: Lola Lemmons
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Dec. (Month) 11 (Day) 1872 (Year)

8. AGE: Years 74 Months 9 Days 2 If less than one day ____ hr. ____ min.

9. Birthplace: Lansburg (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Retired merchant
11. Industry or business ____
FATHER
12. Name: W. H. Booth
13. Birthplace: Ill. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Mary E. Mann
15. Birthplace: Salem Mo (City, town, or county) (State or foreign country)
16. (a) Informant: Gill Booth
(b) Address: Lebanon Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/30/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Buffalo Cemetery
18. (a) Signature of funeral director: Palmer
(b) Address: Lebanon Mo
19. (a) 10-4-1947 (Date received local registrar) (b) Ora Frankeberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 28 year 1947 hour 12 minute 30 A.M.
21. I hereby certify that I attended the deceased from 9/20/47 19____ to 9/28/47 19____ that I last saw him alive on 9/28/47 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Renal Septicemia	1 day
Due to: Acute parenchymatous nephritis and acute prostatitis	1 mo.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: No	
Of autopsy:	

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury: 0
23. Signature: H. G. Hamilton (M. D. ~~or other~~)
Address: Lebanon, Mo Date signed: 9/29/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Received 10/7/47

Laclede County Health Unit

File No. 9-47-165

Date Filed 10/8/47

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 S. R. Palmer

Licensed Embalmer, No. 2208

P. O. Address Lebanon 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.