No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 1 1952

State File No. 39316

BIRTH NO. _____ REG. DIST. NO. 175 PRIMARY REG. DIST. NO. 3036 Registrar's No. 90

1. PLACE OF DEATH
a. COUNTY: Lawrence
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aurora
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Aurora

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Lawrence
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Miller Lincoln
d. STREET ADDRESS (If rural, give location): 0550 0

3. NAME OF DECEASED (Type or Print)
a. (First): Ellis
b. (Middle): Franklin
c. (Last): Boggs

4. DATE OF DEATH (Month) (Day) (Year): 9-6-1952

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 1
8. DATE OF BIRTH: 7-20-1881
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months 1, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Laborer
11. BIRTHPLACE (State or foreign country): Indianapolis 1
12. CITIZEN OF WHAT COUNTRY? —

13a. FATHER'S NAME: John Boggs
13b. MOTHER'S MAIDEN NAME: Harriett Ann Scoles
14. NAME OF ~~HUSBAND OR~~ WIFE: Willie Boggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 500-09-4117
17. INFORMANT'S SIGNATURE OR NAME: Mrs. Willie Boggs — ADDRESS: Miller Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 331X
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/4, 1952, *to* 9/6, 1952, *that I last saw the deceased alive on* 9-6-, 1952, *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. J. Graves, M.D. 0
23b. ADDRESS: Mt. Vernon Mo.
23c. DATE SIGNED: 11/24/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 0
24b. DATE: 9-9-1952
24c. NAME OF CEMETERY ~~OR CREMATORY~~: Pheasant Grove
24d. LOCATION (City, town, or county) (State): S. of Miller Mo.

DATE REC'D BY LOCAL REG.: Nov. 28, 1952
REGISTRAR'S SIGNATURE: Osa McNatt 157
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Monnier-Leiman Funeral Home

(Licensed Embalmer's Statement on Reverse Side)

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

DEC 1 1952

DEC 2 1952

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~~ ....., Student Embalmer No. ....., working under my personal supervision.

Student .....
Student Embalmer

Signed G. R. Leimon

Licensed Embalmer No. 3297

P. O. Address Miller 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.