

FILED FEB 3 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2630

BIRTH NO. 3766 REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 35

1. PLACE OF DEATH a. COUNTY RANDOLPH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY RANDOLPH	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Moberly		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN MOBERLY MO 0883	
d. FULL NAME OF HOSPITAL OR INSTITUTION 600 Johnson		d. STREET ADDRESS (If rural, give location) 600 JOHNSON	
3. NAME OF DECEASED a. (First) RAYMOND		b. (Middle)	c. (Last) BOONE
4. DATE OF DEATH (Month) (Day) (Year) JAN. 26 1953			
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH JAN. 5-1923
9. AGE (In years last birthday)	10. MONTHS	11. DAYS	12. HOURS & MIN. 21
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) MOBERLY MO.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME IRENE BOONE	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME IRENE BOONE ADDRESS 600 JOHNSON
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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. HOW DID INJURY OCCUR?
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from 1-23 , 19 53 , to 1-26 , 19 53 , that I last saw the deceased alive on 1-26 , 19 53 , and that death occurred at 11:00 a.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W. Smith M.D.		23b. ADDRESS MOBERLY MO	23c. DATE SIGNED 1-27-53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE JAN 27-1953	24c. NAME OF CEMETERY OR-CREMATORY ROANOKE	24d. LOCATION (City, town, or county) (State) MO Roanoke Mo
DATE REC'D BY LOCAL REG. 1-27-53	REGISTRAR'S SIGNATURE Carl B. ...	25. GENERAL DIRECTOR'S SIGNATURE ADDRESS Robert L. Carr	

(Licensed Embalmer's Statement on Reverse Side)

305. Bedford St

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

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

Robert S. Carr

Licensed Embalmer No. 3190

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.