

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024921

FILED VS AUG 5 1959

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 66

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fayette</u>	Length of stay in 1b <u>1 day</u>	c. CITY OR TOWN <u>Fayette</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in Hospital, give location) HOSPITAL OR INSTITUTION <u>See Hospital</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>VIRGIL</u> Last <u>BOOTHE</u>			4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>59</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-1981</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Boone County</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>

13a. FATHER'S NAME <u>William Boothe</u>		13b. MOTHER'S MAIDEN NAME <u>Georganna Hill</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Cora Bennis</u> Address <u>11 West Park Ave.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>coronary heart disease</u>	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>natural</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>none</u>	
20c. TIME OF INJURY Hour <u>9 AM</u> a.m. Month <u>7</u> Day <u>15</u> Year <u>59</u> p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>Hillsdale</u> COUNTY <u>Mo.</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>9 AM 7-15-59</u> to <u>6 PM 7-15-59</u> and last saw <u>him</u> live on <u>7-15-59</u> Death occurred at <u>6 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>W. J. Shaw, Jr. M.D.</u> (Degree or title)		22b. ADDRESS <u>Lee Hospital Fayette, Mo</u>		22c. DATE SIGNED <u>7-23-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-18-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillsdale Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Hillsdale Mo.</u>	

24. FUNERAL DIRECTOR <u>Stuart P. Powell Funeral Home</u> ADDRESS <u>107. 4th St</u>		25. DATE RECD. BY LOCAL REG. <u>7-23-59</u>	26. REGISTRAR'S SIGNATURE <u>Mary K. Shell</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 5 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

George D. [unclear]

Licensed Embalmer No. 442

P. O. Address Columbus

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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