

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-004784  
STATE FILE NUMBER

FILED VS FEB 8 1960

Registration District No. 351 Primary Registration District No. 4515 Registrar's No. 13

V. S. 300  
Rev. 1-57

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>SULLIVAN</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>SULLIVAN</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MILAN</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>MILAN</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>SULL. CO. HOSP.</b>		Length of stay in 1b	STREET ADDRESS		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BEAUFORTE</b> Middle <b>ALBERT</b> Last <b>BONE</b>			4. DATE OF DEATH Month <b>1</b> Day <b>27</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/1890</b>	9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GEN FARMING</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>BARBER-</b>	11. BIRTHPLACE (City and state or country) <b>GRAPEVINE TEXAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>JOSEPH AURIE BONE</b>		13b. MOTHER'S MAIDEN NAME <b>SARAH PENNY CHURCHMAN</b>		14. NAME OF HUSBAND OR WIFE <b>LILLY A BONE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WORLD WAR I</b>		16. SOCIAL SECURITY NO. <b>---</b>	17. INFORMANT <b>Lilly A Bone</b> Address <b>Milan Mo</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Unknown</b>					
DUE TO (c) <b>4201</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour <b>---</b> Month, Day, Year a.m. <b>---</b> p.m. <b>---</b>					
20d. INJURY OCCURRED WHILE AT <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		COUNTY STATE
21. I attended the deceased from <b>1-27-60</b> to <b>1-27-60</b> and last saw <sup>him</sup> alive on <b>1-27-60</b> Death occurred at <b>12:50 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>V.H. Robinson</b> (Degree or title) <b>D.O. 2</b>			22b. ADDRESS <b>Milan, Mo.</b>		22c. DATE SIGNED <b>1-27-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JAN 30, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAKWOOD</b>		23d. LOCATION (City, town, or county) <b>MILAN</b>	(State) <b>MO</b>
24. FUNERAL DIRECTOR <b>Legg Funeral Home</b> ADDRESS <b>Milan</b>		25. DATE RECD. BY LOCAL REG. <b>1-30-60</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. M. W. Burnett</b>		

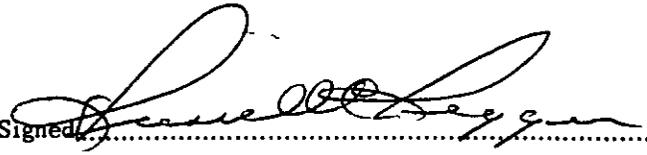
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FEB 8 1960

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 .....  
Signature of Student Embalmer

Signed  .....

Licensed Embalmer No. 3752  
P. O. Address Melrose .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.