

NOV 26 1930

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County *Linn*Registration District No. *464*Township *Adrian*Primary Registration District No. *4277*City *Adrian* (No.)

33405

File No. *13*Registered No. *31*

St.

Ward)

2. FULL NAME

Sallie Jane Boone

(a) Residence. No.

St.

Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *80* yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Fe

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

J.M. Boone

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Apr 19, 1840

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

*90**6**15*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

House-keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Clark Co.

(STATE OR COUNTRY)

Kentucky

10. NAME OF FATHER

Ira Boone

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kentucky

12. MAIDEN NAME OF MOTHER

Elizabeth Figgitt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kentucky

14.

INFORMANT

(Address)

*Ira Boone**Adrian Mo.*

15.

FILE NO.

*Nov 6, 1930**R. H. Schooley*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Oct 4th 1930

17.

I HEREBY CERTIFY, That I attended deceased from *Sept 15, 1930* to *Oct 4th 1930*, that I last saw him alive on *Oct 4, 1930*, and that death occurred, on the date stated above, at *3:30 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Interstitial Nephritis**131**132 B**16-2*

CONTRIBUTORY (SECONDARY)

Arteriosclerosis and Emphysema

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

10/6, 1930

(Address)

Clinical
R. H. Schooley, M. D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

*Mt Labor Cemetery**10/6 1930*

20. UNDERTAKER

ADDRESS

*L. H. Husman**Adrian*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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