

Registration District No. 539

Primary Registration District No. 4320

Registrar's No. 83

1. PLACE OF DEATH:

- (a) County MADISON 2
 (b) City or town MADISON MO
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether

In this community _____
 years, months or days 11 10 30

3. (a) PRINT FULL NAME E. H. BOSS, JR.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Joan Beese 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JULIA 15 1860
 (Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace MADISON MO (City, town, or county) (State or foreign country)

10. Usual occupation (FARMER) Retired

11. Industry or business _____

12. Name EDWIN BOSS

13. Birthplace NO. 914 CHOLEN (City, town, or county) (State or foreign country)

14. Maiden name MARY STUBBS

15. Birthplace NO. 914 CHOLEN (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs E. H. Beese

(b) Address Marguerite Mo.

17. (a) Burial (b) Date thereof 11-7-1939
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marguerite

18. (a) Signature of funeral director Ed Staman

(b) Address Marguerite Mo.

19. (a) 11-7-1939 (b) E. C. Slaughter
 (Date received local registry) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 3
 year 1939 hour 7 minute A M.

21. I hereby certify that I attended the deceased from July 2nd, 1939, to Nov. 5, 1939;
 that I last saw him alive on Nov. 5, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Rheumatism, Osteoarthritis Duration 11 yrs

Due to * Senility

Due to 57W

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 5

23. Signature E. M. Scott (D.O. or other) D.O.
 Address Marguerite, Mo. Date signed Nov 7, 1939

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.

I X 1931

10/10/10

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

40208
Do not use this space.

1. PLACE OF DEATH

(a) County Madison Registration District No. 539
(b) Township Marguard Primary Registration District No. 4320
(c) City..... (d) Street No.....
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No.....

2. PRINT FULL NAME

Elizah Henry Bass
(a) Residence, No. (Usual place of abode, if no street address, write county or city) St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
79 5 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 16 1947 S. C. Scamblen Registrar
P. A. Schwan

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 5, 1939

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify

(Signed) C. M. Scott, M. D.

(Address) Marguard

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
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.

