

Registration District No. 77

Primary Registration District No. 6018A

1. PLACE OF DEATH:

(a) County St. Francois Co.  
(b) City or town Near Farmington  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital No. 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 34 yr. 2 mos. 18 d  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Augustus P. Boarman  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 655

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Un. 1879  
(Month) (Day) (Year)

8. AGE: Years 61 Months Un. Days Un. If less than one day hr. min.

9. Birthplace Ste. Genevieve Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown  
13. Birthplace ? Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace ? Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Records of State Hospt. #4  
(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 2-3-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cemetery of State Hospt #4

18. (a) Signature of funeral director C. T. Lloyd  
(b) Address Farmington, Mo.

19. (a) 2-1-1940 (b) B. L. Robinson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois  
(c) City or town Owl Creek  
(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 2 day 1 year 1940 hour 10:15 a. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 1-1, 1939, to 2-1, 1940;  
that I last saw him alive on 2-1, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia  
Lower Rt. Lobe  
Due to Influenza 54

Due to \_\_\_\_\_  
Other conditions Epilepsy, Diabetes Mellitus  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy Lower Rt. Lobar Pneumonia

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(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 \_\_\_\_\_  
23. Signature Jas. R. Mulvey (M. D. or other) M. D.  
Address Farmington, Mo. Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

V. S. No. 2.  
50M-5-17-39  
Rev. 5-17-39  
U. S. G. P. 1 X19311

944

RECEIVED MAR 12 1940

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**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..... Not embalmed.....

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.**