. S. No. 2
M—9-4-41
v. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 6 1944

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30598

Registration District No. 47

Primary Registration District No. 3308

Registrar's No. 298

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 14 yrs 3 m (Specify whether

In this community 14 yrs 3 m years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lewis 14

(c) City or town Canton Rural 1 (If outside city or town limits, write "RURAL") 2

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Alma Booth

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased DK (Month) (Day) (Year)

8. AGE: Years 54 S | Months | Days | If less than one day hr. min.

9. Birthplace St Louis Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Daniel Booth
13. Birthplace DK (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name DK
15. Birthplace DK (City, town, or county) (State or foreign country)

16. (a) Informant Record

(b) Address

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-11-44 (Month) (Day) (Year)

(c) Place: burial or cremation Kirksville, Mo

18. (a) Signature of funeral director Glen Y. Marpin

(b) Address 712 Court St. Fulton, Mo.

19. (a) 9-11-1944 (Date received local registrar) (b) Josie Morrison Leaff (Registrar's signature)

1141

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sep day 6 year 1944 hour 3 minute P M.

21. I hereby certify that I attended the deceased from 9/1/44, 19, to 9/6/, 1944 that I last saw him alive on 9/5/44, 19 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to Fracture Ribs

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature George W. Lewis (M. D. or other) MD

Address Fulton Mo Date signed 9/7/44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 10-5-44

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 Glen G. Maupin
Licensed Embalmer No. 2725
P. O. Address Fulton, Mo.

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

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

S. No. 2B
[illegible]-5-43
I X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30598

Registration District No. 41 Primary Registration District No. 3000 Registrar's No. 248

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(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)

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Alma Booth

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 S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased (Month) DK (Day) (Year)

8. AGE: Years 54 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 6
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	
Due to Fractured hip	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Nov. 23 1943

(c) Where did injury occur? State Hospital No 1 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Accidently fell on ward (Specify type of place)
While at work? No (e) Means of injury Fell

23. Signature George W Reeves (M. D. or other) MD
Address Fulton Mo Date signed 10/24/44

SUPPLEMENTARY

186a