

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

1. PLACE OF DEATH

(a) County Boonville

(b) City or town Boonville
(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 Missouri (b) County Boonville

(c) City or town Cuba RURAL
(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 THOMAS EDWARD BALESS

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 25
year 1944 hour 8 minute 20 P.M.

21. I hereby certify that I attended the deceased from 11-1, 1944, to 11-24, 1944;
that I last saw him alive on 11-24, 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

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: 11-1-1944
(Month) (Day) (Year)

Duration 3 days

Due to Pneumonia (Pulmonary)

Due to Hypovitaminosis 24 11

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

8. AGE: Years _____ Months _____ Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Cuba, R.R. 1 (City, town, or county) Mo (State or foreign country)

10. Usual occupation _____

Major findings: _____
Of operations _____
Of autopsy _____

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

MOTHER FATHER

11. Industry or business _____

12. Name George E. Boyless

13. Birthplace Cuba (City, town, or county) Mo (State or foreign country)

14. Maiden name Patricia House

15. Birthplace Patasi (City, town, or county) Mo (State or foreign country)

16. (a) Informant Geo. E. Boyless
(b) Address Cuba Route #7 Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-44
(Month) (Day) (Year)

(c) Place: burial or cremation Diggins Cem

18. (a) Signature of funeral director Albert Selong
(b) Address Boonville Mo

19. (a) 11-25-44 (Date received local registrar) (b) H. J. Truman M.D. (Registrar's signature)

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) Manner of injury _____

23. Signature W. H. K. Kerner (M.D. or other)
Address Sullivan, Mo Date signed 11-27-44

RECEIVED
District Health Officer No. 5,
District No. Number 14518
Date Filed 1-13-45

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..... Elbert Long
Licensed Embalmer No. 3504
P. O. Address Courbow, Mo

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb.
Registrar's No. 380

Registration District No. 89 Primary Registration District No. 152281

1. PLACE OF DEATH:
(a) County Crawford
(b) City or town Rural
(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

3. (a) PRINT FULL NAME Thomas E Bales
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 Nov 1
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (less than one day) _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Crawford
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb 25
year 1944 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him/her alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to Pneumonia/Pulmonary hypovitaminosis
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
109.1

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) (c) Means of injury _____
23. Signature D. G. E. Garner (M. D. or other)
Address Sullivan, Mo Date signed _____

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

SUPPLEMENTARY

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

S-2.119