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

FILED OCT 31 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33539  
State File No. \_\_\_\_\_  
Registrar's No. 917-A

|   |                        |  |  |   |   |                                      |  |
|---|------------------------|--|--|---|---|--------------------------------------|--|
| BIRTH NO. _____   |                        | REG. DIST. NO. 128   |  | PRIMARY REG. DIST. NO. 2000   |   | Registrar's No. 917-A                |  |
| 1. PLACE OF DEATH<br>a. COUNTY Greene   |                        |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri b. COUNTY Greene |   |                                      |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield  |                        | c. LENGTH OF STAY (In this place) 8 hours  |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield                                    |   |                                      |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital  |                        |  |  | d. STREET ADDRESS (If rural, give location) 1725 East Commercial  |   |                                      |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) Joseph b. (Middle) V. c. (Last) Bossi   |                        |  | 4. DATE OF DEATH (Month) (Day) (Year) October 19 1949                        |   |   |                                      |  |
| 5. SEX Male   | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married   | 8. DATE OF BIRTH August 26, 1906   |   | 9. AGE (In years last birthday) 43                                  | IF UNDER 1 YEAR Months               | IF UNDER 24 HRS. Days  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Partner-Manager   |                        | 10b. KIND OF BUSINESS OR INDUSTRY Sales Co.  |  | 11. BIRTHPLACE (State or foreign country) Rolla, Missouri   |   | 12. CITIZEN OF WHAT COUNTRY? U.S. A. |  |
| 13a. FATHER'S NAME Joseph Bossi   |                        |  | 13b. MOTHER'S MAIDEN NAME Katie Fleishman                                    |   | 14. NAME OF HUSBAND OR WIFE Mrs. Dott Bossi                         |                                      |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No   |                        | 16. SOCIAL SECURITY NO. Unknown  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bernard B. Bossi, Springfield, Mo. |   |   |                                      |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, anasthenia, etc. It means the disease, injury, or complication which caused death. |                        | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage, massive, from esophageal varix<br>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cirrhosis of liver<br>DUE TO (c)<br>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. |  |   |   |                                      | INTERVAL BETWEEN ONSET AND DEATH 18 hours<br><br>Not known<br><br>5810           |
| 19a. DATE OF OPERATION _____  |                        | 19b. MAJOR FINDINGS OF OPERATION _____   |  |   |   |                                      | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____  |                        | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____   |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____   |   |                                      |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____   |                        | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR? _____  |   |                                      |  |
| 22. I hereby certify that I attended the deceased from 10/19, 1949, to 10/19, 1949, that I last saw the deceased alive on 10/19, 1949, and that death occurred at 8:20 P. m., from the causes and on the date stated above.       |                        |  |  |   |   |                                      |  |
| 23a. SIGNATURE (Degree or title) H. Hoover M.D.   |                        |  |  | 23b. ADDRESS Springfield Mo.  |   | 23c. DATE SIGNED 10/20/49            |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |                        | 24b. DATE Oct 23, 1949   | 24c. NAME OF CEMETERY OR CREMATORY Eastlawn Cemetery                         |   | 24d. LOCATION (City, town, or county) (State) Springfield, Missouri |                                      |  |
| DATE REC'D BY LOCAL REG. 10-24-49   |                        | REGISTRAR'S SIGNATURE W. S. Handley M.D.   |  | 25. FUNERAL DIRECTOR'S SIGNATURE Alma Lehmyer   |   | ADDRESS B. F. W. H. Springfield, Mo. |  |

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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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed Bernard F Wright

Licensed Embalmer No. 4293

P. O. Address Springfield, 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.