

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020415
STATE FILE NUMBER

FILED JUL 7 1959 Registration District No. 27 Primary Registration District No. 4044 Registrar's No. 25

V. S. 300
Rev. 1-57

100

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sturgeon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Sturgeon</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>L</u>		Length of stay in lb <u>50 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>L</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Archie</u> Middle <u>Earl</u> Last <u>Boothe</u>			4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 5 - 1903</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done or most of working life, even if retired) <u>Merchant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Yard</u>	11. BIRTHPLACE (City and state or country) <u>Boone County, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Peter A. Boothe</u>	13b. MOTHER'S MAIDEN NAME <u>Jemina Alspaw</u>	14. NAME OF HUSBAND OR WIFE <u>Mildred Boothe</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give date of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>487-22-2452</u>	17. INFORMANT <u>Mrs. Mildred Boothe, Sturgeon, Mo</u> Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute and Chronic Coronary Thrombosis</u>		<u>Minutes</u>
	DUE TO (c) <u>Arteriosclerosis</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from <u>June 27, 1959</u> to <u>June 27, 1959</u> and last saw ^{her} him alive on <u>June 27, 1959</u> Death occurred at <u>10:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Henry J. Stewart D.O.</u>	22b. ADDRESS <u>Sturgeon, Mo</u>	22c. DATE SIGNED <u>6-29-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/29-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sturgeon, Mo.</u>
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24. FUNERAL DIRECTOR <u>Paul O. Ballou, Centerville, Mo</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>June 29 - 1959</u>	26. REGISTRAR'S SIGNATURE <u>Maud Mc Bride</u>
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securing the medical certification in the specific manner required by 193.140 MoRS 1949.
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
 All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

306

AUG 12 1959

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
Signature of Student Embalmer

Signed *Paul J. Baller*

Licensed Embalmer No. *4206*
P. O. Address *Centralia, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.