

STANDARD CERTIFICATE OF DEATH
STATE OF WYOMING
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

FILE NO. 1947

LOCAL REGISTRAR'S NO. 19

REGISTERED NO. 2334

1. PLACE OF DEATH:

(A) COUNTY Gasconade
(B) CITY OR TOWN Paris, Mo.
(C) NAME OF HOSPITAL OR INSTITUTION: White Hall West of Springfield
(If not in hospital or institution write address or location)
(D) LENGTH OF STAY IN HOSPITAL OR INSTITUTION: 34 yrs (Specify whether years, months or days)
IN THIS COMMUNITY 34 yrs

2. USUAL RESIDENCE OF DECEASED:

(A) STATE Mo. (B) COUNTY Gasconade
(C) CITY OR TOWN Paris, Mo.
(If outside city or town limits, write RURAL)
(D) STREET NO. Springfield Way
(If rural give location with respect to the nearest town)
(E) IF FOREIGN BORN, HOW LONG IN U. S. A. ? _____ YEARS.

3 (A) FULL NAME Fred William Booth

3 (B) IF VETERAN. NAME WAR No 3 (C) SOCIAL SECURITY NO. NO

4. SEX Male RACE Wh 5. COLOR OR MARRIED, DIVORCED Married

6 (B) NAME OR HUSBAND OR WIFE Wassie May Booth 6 (C) AGE OF HUSBAND OR WIFE IF ALIVE 54 YRS.

7. BIRTH DATE OF DECEASED March 2 1883 (Month) (Day) (Year)

8. AGE: YEARS 62 MONTHS 11 DAYS 12 IF LESS THAN ONE DAY HR. _____ MIN. _____

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

10. USUAL OCCUPATION Retired Farmer

11. INDUSTRY OR BUSINESS Retired Farmer

12. NAME Milliea Booth (City, town, or county) (City or foreign country)

13. BIRTHPLACE Wis. (City, town, or county) (State or foreign country)

14. MAIDEN NAME Laura Carter (City, town, or county) (State or foreign country)

15. BIRTHPLACE Wis. (City, town, or county) (State or foreign country)

16 (A) INFORMANT'S OWN SIGNATURE Bessie M. Bartle

(B) ADDRESS Springfield, Mo. 65754

17 (A) Burial (Burial, cremation, or removal) (B) DATE THEREOF 2-17-47 (Month) (Day) (Year)

(C) PLACE, BURIAL OR CREMATION St. George, Mo.

18 (A) SIGNATURE OF FUNERAL DIRECTOR Walter F. Colyer

(B) ADDRESS Springfield, Mo.

19 (A) 2-28-47 (Date received local registrar) (B) J. M. Hanley, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: MONTH Feb DAY 14 YEAR 1947 HOUR 1:00 MINUTE P.M.

21. I HEREBY CERTIFY THAT I ATTENDED THE DECEASED FROM Feb 14 1947 TO Feb 14 1947 THAT I LAST SAW HIM ALIVE ON Feb 14 1947 AND THAT DEATH OCCURRED ON THE DATE AND HOUR STATED ABOVE.

IMMEDIATE CAUSE OF DEATH Coronary Arteriosclerosis DURATION 30 min

DUE TO Arteriosclerosis DURATION 10 yrs

DUE TO _____ DURATION _____

OTHER CONDITIONS (Include pregnancy within 3 months of death) 940a PHYSICIAN

MAJOR FINDINGS: OF OPERATIONS _____ DATE OF OP. _____

OF AUTOPSY _____

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, WHILE AT WORK? (Specify type of place) _____
(E) MEANS OF INJURY _____

23. SIGNATURE OF REGISTRAR J. M. Hanley, M.D. (M. D. OR OTHER) ADDRESS Springfield, Mo. DATE SIGNED 4/28/47

This is a permanent record. The spaces are arranged for typewriter use. Please fill out with typewriter (except signatures) or write plainly with unfading black ink. Every item of information should be carefully supplied. Age should be stated exactly; if unknown, give approximate age. Physicians should state cause of death in plain terms if possible, so that it may be properly classified. Exact statement of occupation is important and must not be omitted.

MARGIN RESERVED FOR BINDING