

Registration District No. 20

Primary Registration District No. 3009

Registrar's No. 380

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Cape Girardeau, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Francis Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution about 2 1/2 wk
 (Specify whether
 In this community _____
 years, months or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau
 (c) City or town Jackson
 (If outside city or town limits, write "RURAL")
 (d) Street No. 304 Florence
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Arvin August Boss

8. (b) If veteran, name war. _____ 8. (c) Social Security 489-03-2899

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married

(b) Name of husband or wife Basie Boss 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased march 31 1875
 (Month) (Day) (Year)

8. AGE: Years 65 Months 7 Days 14 If less than one day hr. _____ min. _____

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

10. Usual occupation Banker

11. Industry or business _____

12. Name Henry E. Boss

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

14. Maiden name Lena Rehress

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

16. (a) Informant's own signature H. E. Boss

(b) Address Jackson, Mo.

17. (a) Buried (b) Date thereof Russell Heights Cemetery
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 11-16-40 (b) J. M. Thompson
 (Date received local registrar) (Registrar's signature)

MOTHER FATHER

(Burial, cremation, or removal)

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 15
 year 1940 hour 8:00 minute _____ A.M.

21. I hereby certify that I attended the deceased from 10-28-40
 _____, 19____, to 11-15- 1940
 that I last saw him alive on 11-15-40
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebellar Hemorrhage
 Duration _____

Due to _____
 Due to _____

Other conditions Atonic Bladder
 (Includes pregnancy within 3 months of death) (Cystitis)

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) ✓
 (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 ✓

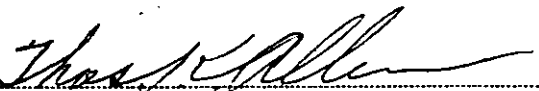
23. Signature Alfredon Estie (M. D. or other) ✓
 Address Jackson Date signed 11-16-40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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



Licensed Embalmer No. 40055

P. O. Address.....

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, above space should be left blank.