

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

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25071
 Do not use this space.

Registered No. 14

1. PLACE OF DEATH

(a) County Grundy Registration District No. 327
 (b) Township Liberty Primary Registration District No. 545-3
 (c) or City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME MRS. LAURA LEONA BOYCE

(a) Residence, No. Grundy Co. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Widow C @ Boyce (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 14 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68 10 12

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Farming
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation He

12. BIRTHPLACE (CITY OR TOWN) Grundy Co Mo (STATE OR COUNTRY)

FATHER 13. NAME Francis Boen Shelton

14. BIRTHPLACE (CITY OR TOWN) Ill. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Mary J. Seals

16. BIRTHPLACE (CITY OR TOWN) Ark. (STATE OR COUNTRY)

17. INFORMANT C. R. Batsen (ADDRESS) Trenton R.R. 6

18. BURIAL, CREMATION, OR REMOVAL PLACE Honey Creek Chapel DATE 6-29 1941

19. FUNERAL DIRECTOR (NAME) P. K. Payne & Son (ADDRESS) Galt Mo

20. FILED 6-27-41 E. C. Weston Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 26 1941

22. I HEREBY CERTIFY that I attended deceased from July 1 1941, to June 25 1941. I last saw her alive on June 25 1941. Death is said to have occurred on the date stated above, at 4:30 a.m.
 The principal cause of death and related causes of importance were as follows:

Carcinoma of stomach
+ gastric bloodlets Date of onset Jan 1941

Other contributory causes of importance: _____

Name of operation Cholecystectomy Date of June 1, 41
 What test confirmed diagnosis? ops. Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) E. J. Hais D. M. D.
 (Address) Trenton Mo

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

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..... *PK Payne Jr*
Licensed Embalmer No. *3400*
P. O. Address *Galt*

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.

Registration District No. 327

Primary Registration District No. 5453

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Sturdy
(b) City or town Liberty sup
(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

3. (a) PRINT FULL NAME Laura Boyce

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

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

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(Burial, cremation, or removal) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of bladder Alcohol + gall bladder Duration _____

Due to too unable to

Due to say when malignancy started

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

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)

(b) 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 _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

W. G. Penlon

STANDARD CERTIFICATE OF DEATH

State File No. 25071
Registrar's No. 14

Registration District No. 327

Primary Registration District No. 5453

1. PLACE OF DEATH:

(a) County Gundy
(b) City or town Liberty
(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: 1 In hospital or institution (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Gundy
(c) City or town rural Liberty
(If outside city or town limits, write "RURAL")
(d) Street No. 6 mi N.W. Salt
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Laura L. Boyce

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-29-41 (b) U. C. Weston (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 26 Year 1941 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. (Immediate cause of death) _____

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

Major findings: Of operations _____
Of autopsy _____

Duration _____
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)
(b) 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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER