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7-39
X23159

DEC 13 1941 735
Registration District No. 735

Primary Registration District No. 3034

State File No. _____
Registrar's No. 247

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Moberly Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 514 So. Williams
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether)
In this community 37 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Randolph
(c) City or town Moberly
(If outside city or town limits, write "RURAL")
(d) Street No. 514 So. Williams
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME FREDERICA MARY Boice
3. (b) If veteran, name war none
3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec, day 4th, year 1941 hour 1 minute 45 A.M.
21. I hereby certify that I attended the deceased from 1930, 19____, to Dec. 4, 1941;

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Hiram W. Boice 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased March - 27 - 1873
(Month) (Day) (Year)

that I last saw her alive on Dec 4, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death angina pectoris
Duration _____

8. AGE: Years 68 Months 8 Days 7 If less than one day hr. _____ min. _____

Due to _____
Due to _____

9. Birthplace Oak Ridge Mo.
(City, town, or county) (State or foreign country)

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

10. Usual occupation House Wife

Major findings: _____
Of operations _____

12. Name William L. Horne
13. Birthplace Harrisburg Penn.
(City, town, or county) (State or foreign country)

Of autopsy none

14. Maiden name Louise Gumstern
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Hiram W. Boice
(b) Address 514 So. Williams

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? _____

17. (a) Burial (b) Date thereof Dec-6-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Moberly Mo.

While at work? _____ (Specify type of place)
(e) Means of injury _____

18. (a) Signature of funeral director Snow Funeral Home
(b) Address Moberly Mo.

23. Signature Dr. Gladys meals (M. D. or other) 100
Address 531 1/2 W. 8th Date signed Dec 4

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

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

MOTHER FATHER

DEC 12 1923

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.....

R. M. Carter

Licensed Embalmer No. *4117*

P. O. Address *Moberly Mo*

FILED

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

STANDARD CERTIFICATE OF DEATH

State File No. 39200

Registration District No. 735

Primary Registration District No. 3034

Registrar's No.

1. PLACE OF DEATH

(a) County Randolph
(b) City or town Moberly
(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)

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..... day.....
year 1941 hour..... minute..... M.
21. I hereby certify that I attended the deceased from.....
19....., 19.....
that I last saw him..... alive on....., 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

3. (a) PRINT FULL NAME Frederica M Bace
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.....
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Mar. 27 1872
(Month) (Day) (Year)

8. AGE: Years 68 Months 8 Days..... If less than one day..... min.
hr.

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.....
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) 12-5-41 (b) Leah Williams
(Date received local registrar) (Registrar's signature)

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

Major findings:
Of operations.....
Of autopsy.....

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?
(Specify type of place)
While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

MOTHER FATHER

S-39200