

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37592

State File No. _____

FILED NOV 18 1943

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 263

1. PLACE OF DEATH:

(a) County ADAIR
(b) City or town WIKKAVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Nurses Community Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LEWIS 56
(c) City or town WILLIAMSTOWN 0
(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 _____

3. (a) PRINT FULL NAME

CLELLA Boyd

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 4, 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 2 5 hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER
12. Name John Boyd Mo
13. Birthplace not known Mo
(City, town, or county) (State or foreign country)
14. Maiden name Tibbaly Ewart
15. Birthplace not known Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Chas. Sample

(b) Address Williamstown Mo

17. (a) (Burial, cremation, or removal) Burial (b) Date thereof 10/10/43
(Month) (Day) (Year)

(c) Place: burial or cremation Williamstown Mo

18. (a) Signature of funeral director James A. Alder
(b) Address Williamstown Mo

19. (a) 10/15/43 (b) Dr. J. Warner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day ninth
year 1943 hour Five minute 30 P.M.

21. I hereby certify that I attended the deceased from August
eleventh 1943 to October 9 1943
that I last saw her alive on October 8 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

Due to infection of lungs

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: No operations
Of operations _____
Of autopsy No 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)

(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 A. R. Schultz (M. D. or other) DO
Address 503 E. Benton, Williamstown Date signed 10/19/43

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

1044

Mrs. J. L. Wagner
515 No. Meridian

RECEIVED

District Health Officer No. 10

District File Number 11-43-1851

Date Filed NOV 16 1943

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 Myself

....., Registered Apprentice No.

working under my personal supervision.

Signed

James A. Coder
.....
Licensed Embalmer No. 2532

P. O. Address. Lewistown 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 this body is not embalmed, fact should be so stated above.