

FILED MAY 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13523

BIRTH NO. 134 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3061 Registrar's No. 158

1. PLACE OF DEATH a. COUNTY St. Francois			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Francois		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Flat River		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Flat River		d. STREET ADDRESS (If rural, give location) 506 Low St.
3. NAME OF DECEASED (Type or Print) a. (First) CLARA b. (Middle) MAE c. (Last) BOYER			4. DATE OF DEATH (Month) (Day) (Year) May 2 1949		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed 2	8. DATE OF BIRTH Dec- 15- 1874	9. AGE (In years last birthday) Months Days 74 4 17	IF UNDER 1 YEAR Hours Min. 5 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ste. Genevieve, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Leo Aubuchon		13b. MOTHER'S MAIDEN NAME Mary Scharlerville	14. NAME OF HUSBAND OR WIFE Donor Micheal Boyer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Gene Boyer Flat River, Mo		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Essential Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Five days 331X
19a. DATE OF OPERATION <input checked="" type="checkbox"/>	19b. MAJOR FINDINGS OF OPERATION <input checked="" type="checkbox"/>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 18th, 1946 , to May 2nd, 1949 , that I last saw the deceased alive on May 2nd, 1949 , and that death occurred at 11:04 PM from the causes and on the date stated above.					
23a. SIGNATURE W. O. Morris		(Degree or title) M.D. 2	23b. ADDRESS Elvins, Missouri		23c. DATE SIGNED May 3rd 1949
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 5, 1949	24c. NAME OF CEMETERY OR CREMATORY Calvary Ceme.	24d. LOCATION (City, town, or county) (State) Farmington, Missouri		
DATE REC'D BY LOCAL REG. May 4, 1949	REGISTRAR'S SIGNATURE Ether Rudloff	FUNERAL DIRECTOR'S SIGNATURE Sparks	ADDRESS Flat River, Mo		

RECEIVED

Health Officer No. 4
No. 549-6
5-9-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *Murphy Sparks*

Licensed Embalmer No. 4236

P. O. Address. *Flat River, 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.