

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

411-668

FILED DEC 30 1950

State File No. ....

|  |  |   |  |   |  |  |   |  |
|--|--|---|--|---|--|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>209</u>   |  | PRIMARY REG. DIST. NO. <u>3043</u>  |  | Registrar's No. <u>422</u>   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Marion</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>Marion 0644</u> |  |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Harrisonal</u>   |  | c. LENGTH OF STAY (in this place)   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Harrisonal</u>  |  | 0  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>ST Elizabeth Hospital</u>  |  |   |  | d. STREET ADDRESS (If rural, give location) <u>212. S 8TH. ST</u>   |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <u>John</u> b. (Middle) <u>J.</u> c. (Last) <u>Boyle</u>  |  |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 14. 50</u> |   |  |  |   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>   |  | 8. DATE OF BIRTH <u>OCT. 12. 1878</u>                                      |   |  |
| 9. AGE (In years last birthday) <u>79</u>  |  | IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u>  |  | IF UNDER 1 MTH. Hours <u></u> Mins. <u></u>   |  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer.</u>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>STreet Dept.</u>    |   | 11. BIRTHPLACE (State or foreign country) <u>Harrisonal Mo 0</u>                           |  | 12. COUNTRY OF WHAT COUNTRY? <u>U.S.A</u> |  |
| 13a. FATHER'S NAME <u>James Boyle</u>  |  |   | 13b. MOTHER'S MAIDEN NAME <u>Margaret Murphy.</u>        |   | 14. NAME OF HUSBAND OR WIFE _____  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>   |  |   | 16. SOCIAL SECURITY NO. _____                            |   | 17. INFORMANT'S SIGNATURE OR NAME <u>Mary Boyle. 212 S 8th Harrisonal Mo</u> ADDRESS _____ |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)  |  | MEDICAL CERTIFICATION   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH          |  |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.   |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bleeding Septic Ulcer</u>                                   |  |   |  |  | <u>2 weeks</u>                            |  |
|  |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. |  |   |  |  | <u>2 yrs</u>                              |  |
|  |  | DUE TO (b) <u>Arteriosclerosis</u>  |  |   |  |  | <u>2 yrs.</u>                             |  |
|  |  | DUE TO (c) <u>Chronic Nephritis</u>   |  |   |  |  | <u>2 yrs.</u>                             |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  | <u>Chronic Nephritis</u>  |  |   |  |  | <u>2 yrs.</u>                             |  |
| 19a. DATE OF OPERATION _____   |  | 19b. MAJOR FINDINGS OF OPERATION _____  |  |   |  |  |   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) <u>4200</u>   |  |  |   |  |
| 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:45 p.m.</u> , from the causes and on the date stated above. |  |   |  |   |  |  |   |  |
| 23a. SIGNATURE <u>Jac Landham</u> (Degree or title) _____  |  |   |  | 23b. ADDRESS <u>1001 Bldg</u>   |  | 23c. DATE SIGNED <u>12/20/50</u>   |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 24b. DATE <u>12-16-50</u>   |  | 24c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>  |  | 24d. EDUCATION (City, town, or county) (State) <u>Harrisonal Marion Mo</u> |   |  |
| DATE REC'D BY LOCAL REG. <u>12-20-50</u>   |  | REGISTRAR'S SIGNATURE <u>Dr. E.M. Tucker</u>  |  | FUNERAL DIRECTOR'S SIGNATURE <u>W. Fisher</u>   |  | ADDRESS <u>James O'Connell Harrisonal Mo</u>                               |   |  |

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

RECEIVED DEC 27 1950  
MARION CO. HEALTH DEPT.  
DATE FILED DEC 28 1950

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed Michael J. O'Connell

Licensed Embalmer No. 3246

P. O. Address Hannibal 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.