

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **26090**

FILED AUG 5 - 1954

BIRTH NO. _____		REG. DIST. NO. <b>366</b>		PRIMARY REG. DIST. NO. <b>6242</b>		Registrar's No. <b>42</b>				
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <b>MISSOURI</b>				b. COUNTY <b>WASHINGTON</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>RURAL-KINGSTON</b>			c. LENGTH OF STAY (In this place) <b>LIFE</b>		c. CITY OR TOWN <b>RURAL-KINGSTON</b>		d. Is Residence within limits of city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Star Rt. Blackwell</b>				e. STREET ADDRESS (If rural, give location) <b>Star Rt. Blackwell</b>				1160		
3. NAME OF DECEASED (Type or Print) a. (First) <b>MARY</b>			b. (Middle) <b>FRANCIS</b>		c. (Last) <b>BOYER</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>July, 30 1954</b>			
5. SEX <b>Female</b>		6. COLOR (OR RACE) <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>2-26-1902</b>		9. AGE (In years last birthday) <b>52</b>		
						IF UNDER 1 YEAR Months <b>5</b>		IF UNDER 1 YEAR Days <b>4</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Washington County, Mo</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Fred Wickerham</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Clarence D. Boyer</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Clarence D. Boyer</b>					ADDRESS <b>Blackwell, RT. Mo.</b>	
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) <b>Carcinoma left breast metastasis cervical glands</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Died Hemorrhage from carcinoma</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>170 X</b>						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)						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 <b>6/1</b> , 19 <b>52</b> to <b>7/30</b> , 19 <b>54</b> that I last saw the deceased alive on <b>7/30</b> 19 <b>54</b> and that death occurred at <b>6:45 P. M.</b> , from the causes and on the date stated above.										
23a. SIGNATURE (In full name) <b>H. H. Russell</b>				23b. ADDRESS <b>Potosi Mo.</b>			23c. DATE SIGNED <b>7/31/54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8-2-1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Joachims. Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Old Mines. Mo</b>				
DATE REC'D BY LOCAL REG. <b>9/2/54</b>		REGISTRAR'S SIGNATURE <b>H. H. Russell</b>		403-10		25. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Smith</b>		ADDRESS <b>Potosi. Mo</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

AUG 4 1954

WASH. COUNTY HEALTH DEPT.

File No. \_\_\_\_\_

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed *Mary M. Smith*  
Licensed Embalmer No. *439*

P. O. Address *Potasi, W.V.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

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