

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 27 1955

BIRTH NO. _____ REG. DIST. NO. **294** PRIMARY REG. DIST. NO. **3056** Registrar's No. **94**

883
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Randolph	
b. CITY OR TOWN Moberly		c. CITY OR TOWN Moberly	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Woodland Hospital		STREET ADDRESS (If rural, give location) 418 So. Williams 0883	
3. NAME OF DECEASED a. (First) Moses b. (Middle) C. c. (Last) Boswell		4. DATE OF DEATH (Month) (Day) (Year) Apr 17th 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) N.M.	8. DATE OF BIRTH Apr. 7 1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 86 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (City and State or Foreign Country) Mo		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME James O Boswell		13b. MOTHER'S MAIDEN NAME Susan Hubbard	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME Miss P. Pearsall ADDRESS Jacksonville, Texas
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart disease INTERVAL BETWEEN ONSET AND DEATH ? ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4200	
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) (Min.)		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 April 8, 1955 , to April 17, 1955 , that I last saw the deceased alive on April 17, 1955 and that death occurred at 9AM m., from the causes and on the date stated above.			
23a. SIGNATURE Thos. S. Fleming (Degree or title)		23b. ADDRESS Moberly	23c. DATE SIGNED 4-19-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-19-55	24c. NAME OF CEMETERY OR CREMATORY Oakland	24d. LOCATION (City, town, or county) (State) Moberly, Mo
DATE REC'D BY LOCAL REG 4-19-55	REGISTRAR'S SIGNATURE Teaherlowe 269	25. FUNERAL DIRECTOR'S SIGNATURE Mahan and Son, Moberly, Mo ADDRESS	

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..... *Frank D. DeWitt*

Licensed Embalmer No. *3021*

P. O. Address..... *Mobile*

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.