

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH41368
State File No. 5237

BIRTH NO.		REG. DIST. NO. 149		PRIMARY REG. DIST. NO. 1002		Registrar's No. 5237	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY Jackson		a. STATE Missouri		b. COUNTY Clay			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. LENGTH OF STAY (in this place) 6 hrs.		c. CITY OR TOWN Liberty		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hosp.				e. STREET ADDRESS (If rural, give location) R 3			
3. NAME OF DECEASED			4. DATE OF DEATH				
a. (First) MARY	b. (Middle) M.	c. (Last) BOYER	4. DATE OF DEATH	(Month) Nov.	(Day) 30	(Year) 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug 10-1881	9. AGE (In years last birthday) 75	if UNDER 1 YEAR Months	if UNDER 12 Hrs. Hours	if UNDER 1 Mts. Mts.
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 (City and State or Foreign Country) Ray Co. Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Riley O'Dell		13b. MOTHER'S MAIDEN NAME Jane Clark		14. NAME OF HUSBAND OR WIFE Moses Boyer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 123		17. INFORMANT'S SIGNATURE OR NAME Mrs. Forest Primm			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion				4-8 hrs	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS				4201	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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 Nov 29, 1956, to Nov 30, 1956, that I last saw the deceased alive on Nov 30, 1956, and that death occurred at 9 p.m., from the causes and on the date stated above.							
23a. SIGNATURE James W. Willoughby, MD (Degree or title)				23b. ADDRESS Liberty Mo		23c. DATE SIGNED 12-1-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Nov 30-56	24c. NAME OF CEMETERY OR CREMATORY Fairview		24d. LOCATION (City, town, or county) Liberty Mo		24e. (State) Mo
DATE REC'D BY LOCAL REG. 12-4-56		REGISTRAR'S SIGNATURE Neva Marshall		25. FUNERAL DIRECTOR'S SIGNATURE Plummer-Cresser Co. Liberty Mo			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
James W. Willoughby

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 *John L. Linder of*

Licensed Embalmer No. *444*

P. O. Address *2. Century*

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.