

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9329

STATE FILE NUMBER

FILED APR 4 - 1957

Registration District No. 187 Primary Registration District No. 3048 Registrar's No. 89

1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Republic</u> 0390	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chillicothe Hosp.</u> Length of stay in 1b <u>1 day</u>		d. STREET ADDRESS (If outside, give location) Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>CARL O BOYSAI</u> First Middle Last			4. DATE OF DEATH <u>MAY 21 1957</u> Month Day Year		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 18 1881</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	11. BIRTHPLACE (City and state or country) <u>Seymore IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOHN BOYSAI</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		

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. <u>707-16-8656</u>	17. INFORMANT <u>MRS Jessie BoySAI</u> Address <u>Republic, MO.</u>
--	--	---

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from <u>March 20-57</u> to <u>March 21-57</u> and last saw her/him alive on <u>March 21-57</u> . Death occurred at <u>8:14</u> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Joseph F. Gale M.D.</u>	22b. ADDRESS <u>Chillicothe MO</u>	22c. DATE SIGNED <u>3-25-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/24/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLE GROVE</u>	23d. LOCATION (City, town, or county) (State) <u>Trenton MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>J. Gordon Blackmore Trenton MO</u>	25. DATE RECD. BY LOCAL REG. <u>3/25/57</u>	26. REGISTRAR'S SIGNATURE <u>Frances B Nail</u>	

300  
1-56 0

securing the medical certification in this specific manner required by the Missouri Health Code. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

Dr. GALE

(Licensed Embalmer's Statement on Reverse Side)

APR 4 1957

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 *David Roberts*

Licensed Embalmer No. *492*

P. O. Address *Leicester*

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.