

FILED JUN 12 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

57 0 17 8 5 8

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 3040 Registrar's No. 146

1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LIVINGSTON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CHILLICOTHE</u>		c. CITY OR TOWN <u>CHILLICOTHE</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>60 YEARS</u>		• STREET ADDRESS (If rural, give location) <u>1320 CLAY STREET</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>CITY HOSPITAL</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>ELLA</u>	b. (Middle) <u>SPENCER</u>	c. (Last) <u>BOYD</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 1, 1957</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>24 AUGUST 1867</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 12 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>COLUMBUS, OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13a. FATHER'S NAME <u>James Spencer</u>	13b. MOTHER'S MAIDEN NAME <u>Maria Bock</u>	14. NAME OF HUSBAND OR WIFE <u>Scott L. Boyd</u>
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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>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Don C. Boyd</u>	ADDRESS <u>812 CALHOUN</u>
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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, athermia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET (AND DEATH) <u>[REDACTED]</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Diabetes</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Fractured hip</u> 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 _____	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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)
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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? _____
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22. I hereby certify that I attended the deceased from 4-20, 1957, to 6-1, 1957, that I last saw the deceased alive on 5-31, 1957, and that death occurred at 24 m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>D.O.</u>	23b. ADDRESS <u>Chillicothe</u>	23c. DATE SIGNED <u>6-1-57</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>6-2-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>WHEELING</u>	24d. LOCATION (City, town, or county) (State) <u>WHEELING MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>6-1-57</u>	REGISTRAR'S SIGNATURE <u>Frances B Neel</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>NORMAN FUNERAL HOME</u>	ADDRESS <u>CHILLICOTHE, MO</u>
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WRITE PLAINLY USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 *Elton Arman*.....

Licensed Embalmer No. *4036*.....

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