

Health,
& Welfare
Public
Service

Dr. Greene

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2000

FILED FEB 13 1958

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 33

300
1-57

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| 1. PLACE OF DEATH a. COUNTY <u>Marion</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Hannibal</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>800 Walnut</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <u>800 Walnut</u> |
| | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Gibbons</u> Last <u>Boyles</u> | 4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1958</u> |
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| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 24, 1866</u> | 9. AGE (In years last birthday) <u>91</u> | 10. FUNDER 1 YEAR Months <u>0</u> Days <u>0</u> | 11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> |
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| 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 country) <u>Marion County, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Pryor Maddox</u> | 13b. MOTHER'S MAIDEN NAME <u>Betty Tipton</u> | 14. NAME OF HUSBAND OR WIFE <u>Samuel Boyles</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) | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Mr. Everett Gibbons, 800 Walnut St.,</u> Address |
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| 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>Aplastic Anemia</u> Hannibal, Mo. INTERVAL BETWEEN ONSET AND DEATH <u>19 months</u> DUE TO (b) _____ DUE TO (c) _____ | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Surg. Arterio-sclerotic Pt. foot</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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| 20c. TIME OF INJURY Hour _____ 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 <u>Hannibal, Mo.</u> | COUNTY _____ STATE _____ |
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| 21. I attended the deceased from <u>6-25-56</u> to <u>1-31-58</u> and last saw her/him alive on <u>1-31-58</u> Death occurred at <u>3:00 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u> | 22b. ADDRESS <u>100 S. Sixth, Hannibal, Mo.</u> | 22c. DATE SIGNED <u>2-4-58</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Feb 3, 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u> | 23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>H.M.O'Donnell, Hannibal, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>2-6-58</u> | 26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Lucke</u> |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

RECEIVED FEB 10 1958
MARION CO. HEALTH DEPT
DATE FILED FEB 10 1958

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 *J. M. O'Donnell*

Licensed Embalmer No. 3889
P. O. Address Hannibal, 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.