

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
42

58-020942
STATE FILE NUMBER
701

FILED JUL 7 1958 Registration District No. _____ Primary Registration District No. 1000 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Joseph 6117 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence Length of stay in lb 14 months		d. STREET ADDRESS (If outside, give location) 3508 Penn. St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last Irene Boyd			4. DATE OF DEATH Month Day Year June 28, 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1920
9. AGE (In years last birthday) 38		FUNDER 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) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Farmersville, Texas
12. CITIZEN OF WHAT COUNTRY? USA.		13a. FATHER'S NAME Robert M. Boyd	
13b. MOTHER'S MAIDEN NAME Frances Corn		14. NAME OF HUSBAND OR WIFE Never Married	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs William Barton, St. Joseph, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Acute Myocarditis DUE TO (c) Cardiac decompensation Rheumatic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH State Yes Yes Yes
19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		415X	
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 <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>APR 13</u> to <u>APR 20</u> and last saw her alive on <u>APR 20 1958</u> Death occurred at <u>about 4:00 a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>McGriness M.D.</u>		22b. ADDRESS <u>St Joseph Mo</u>	22c. DATE SIGNED <u>7-1-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>6/30/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Frazier Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Buchana Co. Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>John H. Murray, Gower, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>July 3 1958</u>	26. REGISTRAR'S SIGNATURE <u>Wm. Clark Goodell</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 Me....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed John H. Murray.....

Licensed Embalmer No. 2893.....
P. O. Address Lowell, Ma.....

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.