

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000178

STATE FILE NUMBER

REG FEB 9 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 53

300  
-57

1. PLACE OF DEATH a. COUNTY <b>BOONE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>BOONE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Columbia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KashKONONG</b> c159
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>UNIVERSITY Hospital</b>		Length of stay, in 1b <b>7 days</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>VIDA WEST BOLES</b>			4. DATE OF DEATH Month Day Year <b>1 31 59</b>
5. SEX <b>1</b> <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-21-91</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE (In years last birthday) <b>67</b> IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <b>ARKANSAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John WEST</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>NONE</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>Hospital RECORD</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary edema</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Myocardial infarction 2 weeks &amp; later on 12 hour</b>			19. WAS AUTOPSY PERFORMED? <b>4200</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
DUE TO (c) <b>Arteriosclerotic Heart Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
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 <b>January 30, 1959</b> to <b>January 31, 1959</b> and last saw her alive on <b>January 31, 1959</b> Death occurred at <b>9:45 am</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>W. B. Kyrath, M.O.</b>		22b. ADDRESS <b>University Hosp, Columbia, Mo.</b>	22c. DATE SIGNED <b>1-31-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>2-1-59</b>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <b>Kashkonong Mo</b>
24. FUNERAL DIRECTOR ADDRESS <b>Parker Funeral Service Columbia</b>		25. DATE RECD. BY LOCAL REG. <b>Feb 1 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>

(Licensed Embalmer's Statement on Reverse Side)

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

Student .....  
Signature of Student Embalmer

Signed *Douglas J. German* .....

Licensed Embalmer No. *5037* .....

P. O. Address *Columbus* .....

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.