

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010230
STATE FILE NUMBER

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 17

300
-57

1. PLACE OF DEATH a. COUNTY <u>Morgan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Morgan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Versailles</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Versailles</u> ⁰⁷⁵⁰
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>502 W. Washington Lifetime</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>502 W. Washington</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Eliza</u> Middle <u>Jane</u> Last <u>Boiley</u>			4. DATE OF DEATH Month <u>Apr.</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1874</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Morgan Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John Price</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Howard</u>		14. NAME OF HUSBAND OR WIFE <u>Commodore Boilers</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>Unknown</u>	17. INFORMANT Address <u>Mrs. O. J. Sutz Fulton, 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>Cerebrovascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>advanced generalized arteriosclerosis</u>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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.) <u>331X</u>
20c. TIME OF INJURY Hour <u>7:00</u> Month <u>Apr</u> Day <u>9</u> Year <u>1959</u> a.m. <u>P</u> 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>Versailles, Mo.</u>	COUNTY	STATE
21. I attended the deceased from <u>1950</u> to <u>April 9, 1959</u> and last saw <u>her</u> alive on <u>4.8.59</u> Death occurred at <u>7:00 P</u> m of the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>Jack Gunn MD</u> (Degree or title)		22b. ADDRESS <u>Versailles, Mo.</u>		22c. DATE SIGNED <u>4.9.59</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11 Apr. 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Versailles Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>Versailles, Mo.</u>
--	--------------------------------	--	--

24. FUNERAL DIRECTOR <u>Kidwell Funeral Home Versailles Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>4-11-59</u>	26. REGISTRAR'S SIGNATURE <u>J. J. Waldum</u>
--	---------	--	--

(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 *Raymond C. Larkin*

Licensed Embalmer No. *4626*
P. O. Address *Wesley, 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.