

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-025927

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

209 3043 205

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 205 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Marion</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal, Missouri.</u> Length of stay in 1b <u>3Wks</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Levering Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Ralls,</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> c. CITY OR TOWN <u>Perry, Missouri.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Perry, Missouri.</u>	
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3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>ELMER</u> Last <u>BOYD.</u>			4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1959.</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-10-1881</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance agency</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (City and state or country) <u>Audrain Co., Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Allen Boyd</u>			13b. MOTHER'S MAIDEN NAME <u>Mattie Mundy</u>			14. NAME OF HUSBAND OR WIFE <u>Berta Boyd. Rxxxxx.</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.		17. INFORMANT Address <u>Berta Boyd, Perry, 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>Terminal bronchial pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> <u>6 months</u> DUE TO (c) <u>Hypertrophy of prostate</u> <u>0 months</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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		COUNTY		STATE	
21. I attended the deceased from <u>1/27/59</u> to <u>6/25/59</u> and last saw him ^{her} alive on <u>6/25/59</u> Death occurred at <u>2100 3:10 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>B. L. Murphy M.D.</u>				22b. ADDRESS <u>Hannibal, Missouri.</u>		22c. DATE SIGNED <u>7/11/59</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 27, 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lickcreek Cemetery, Perry, Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>Perry, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Clyde L. ... Perry, Mo.</u>		25. DATE RECD. BY LOCAL REC. <u>7-13-59</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. ...</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

RE I. TS

1901-01-15

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Olyde C. Wick*

Licensed Embalmer No. 383

P. O. Address *Pennington*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.