URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 16 1959

59-034877

STATE FILE NUMBER

Registration District No. 3251 Primary Registration District No. 4480 Registrar's No. 35

1. PLACE OF DEATH
a. COUNTY Schuyler
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Enroute to hospital
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Near Greentop, Missouri
Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Iowa b. COUNTY Davis
c. CITY OR TOWN Bloomfield
Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Wyaconda Twp RFD6
Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First James Middle Donnell Last Boyd
4. DATE OF DEATH Month Sept. Day 5, Year 1959
5. SEX male
6. COLOR OR RACE white
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH May 21, 1899
9. AGE (last birthday) 60
IF UNDER 1 YEAR Months 3 Days 14 IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (City and state or country) Illinois
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Ewing D. Boyd
13b. MOTHER'S MAIDEN NAME Dora Korn
14. NAME OF HUSBAND OR WIFE Agnes Boyd
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. 481-22-4828
17. INFORMANT Address Mrs. Agnes Boyd, RFD#6 Bloomfield Ia.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Medullary failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Massive cerebral hemorrhage
DUE TO (c) Hypertension
INTERVAL BETWEEN ONSET AND DEATH 1 hour
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 6-22-55, to 9-5-59 and last saw ~~her~~ him alive on 9-5-59
Death occurred at 1:15 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. R. Stoker D.O.
22b. ADDRESS Lancaster Mo.
22c. DATE SIGNED 9-12-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Sept, 5, 59
23c. NAME OF CEMETERY OR CREMATORY Howell Cemetery
23d. LOCATION (City, town, or county) (State) R.R.6 Bloomfield, Iowa
24. FUNERAL DIRECTOR Price & Norman ADDRESS Lancaster Mo
25. DATE RECD. BY LOCAL REG. 9-12-59
26. REGISTRAR'S SIGNATURE Mrs. R. J. Drake

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

ENDED

SEP 28 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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Nova E. Foster
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, Mo.

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