

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042757

VS NOV 20 1960  
DEED

Registration District No. 195 Primary Registration District No. \_\_\_\_\_ Registrar's No. 98-60 STATE FILE NUMBER \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <u>McDonald</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>McDonald</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Powell</u>	Length of stay in 1b <u>81 yrs</u>	c. CITY OR TOWN <u>Powell</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Her Home</u>		d. STREET ADDRESS (If outside, give location) <u>Powell</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Lavada</u> Last <u>Boles</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 79</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Camp</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Owens</u>		14. NAME OF HUSBAND OR WIFE <u>John Boles</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>none</u>		17. INFORMANT <u>Ray Boles</u> address <u>Beldon 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>Hemiplegia</u> <u>Cerebral accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
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 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>10-1-60</u> to <u>11-17-60</u> and last saw her <u>her</u> alive on <u>11-1-60</u> Death occurred at <u>3 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>J. Blankenship M.D.</u>		22b. ADDRESS <u>Neosho Mo</u>	22c. DATE SIGNED <u>11-18-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov-19-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St</u>	23d. LOCATION (City, town, or county) (State) <u>McDonald County Missouri</u>

24. FUNERAL DIRECTOR <u>McQueen Funeral Home</u> ADDRESS <u>Wheaton, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 21, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mary A. Bradley</u> <u>G.W. BLANKENSHIP, M.D.</u>
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DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**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 Paul D. Herbert

Licensed Embalmer No. 45-76

P. O. Address Cassille, 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.