

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-030782

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 141 Primary Registration District No. 5551 Registrar's No. 143

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 4 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		c. CITY OR TOWN <u>West Plains</u>	
Length of stay in lb		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rover Route</u>		d. STREET ADDRESS (If outside, give location) <u>Rover Route</u>	
3. NAME OF DECEASED (Type or print) First <u>Retus</u> Middle <u>Robert</u> Last <u>DeBoard</u>		4. DATE OF DEATH Month <u>8</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/1875</u>
9. AGE (last birthday) <u>86</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Norris City, Ill.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Franklin Joel DeBoard</u>	
13b. MOTHER'S MAIDEN NAME <u>Margaret Anne McKenzie</u>		14. NAME OF HUSBAND OR WIFE <u>Ada Melissa DeBoard, Dec'd.</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 <u>Mrs. Lora Francis, West Plains, Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>			<u>One hour</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>			<u>1 year</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>Prostatic hypertrophy & urinary obstruction</u>			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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>October 1961</u> to <u>8/27/62</u> and last saw ^{her} him alive on <u>8/14/62</u>			
Death occurred at <u>12:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>M. L. Fowler</u> (Degree or title) <u>MD</u>		22b. ADDRESS <u>West Plains Mo</u>	
22c. DATE SIGNED <u>8/28/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>August 30, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Amy Union Cemetery</u>		23d. LOCATION (City, town, or county) <u>Howell County Missouri</u>	
24. FUNERAL DIRECTOR <u>Carter Funeral Home, West Plains, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-29-62</u>	
26. REGISTRAR'S SIGNATURE <u>Beatrice Cooke</u>			

SEP 21 1962

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 Leiland Carter

Licensed Embalmer No. 4576

P. O. Address West Plains 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.