

FILED NOV 4 1957

STANDARD CERTIFICATE OF DEATH

34848

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1161S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Dekalb</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Clarksdale</u> ²³⁰ 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>Mo. Methodist Hosp.</u>		Length of stay in 1b <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>_____</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Royston</u> Last <u>Boy</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1957</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>Nov. 18, 1869</u>
9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Tennessee</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Adam Boy</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Harper</u>		14. NAME OF HUSBAND OR WIFE <u>Nora Messick Boy</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 Address <u>Mrs. Chris Olson, St. Joseph, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
DUE TO (b) <u>Coronary thrombosis</u>			<u>minutes</u>
DUE TO (c) <u>Arteriosclerotic heart disease</u>			<u>260x yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus; diabetic gangrene right lower extremity with surgical amputation the morning of this patient's death.</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>_____</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm; factory, street, office bldg., etc.) <u>_____</u>	
20f. CITY, TOWN, OR LOCATION <u>_____</u>		COUNTY <u>_____</u>	STATE <u>_____</u>
21. I attended the deceased from <u>June 5, 1957</u> to <u>October 23, 1957</u> and last saw her/him alive on <u>October 23, 1957</u> Death occurred at <u>5:00</u> p. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Caryl H. Totten M.D.</u>		22b. ADDRESS <u>Physicians & Surg. Bldg.</u> <u>St. Joseph, Missouri</u>	
22c. DATE SIGNED <u>10/28/57</u>		23. NAME OF CEMETERY OR CREMATORY <u>Union Chapel Cemetery</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 26, 1957</u>	23d. LOCATION (City, town, or county) (State) <u>Clarksdale, Missouri</u>
24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman Inc.</u>		25. DATE RECD. BY LOCAL REG. <u>Oct. 30, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>
ADDRESS <u>St. Joseph, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 

Licensed Embalmer No. 4679
P. O. Address St. Joseph, 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.