

JUN 14 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

19673
Do not use this space.

1. PLACE OF DEATH

(a) County St. Francois Registration District No. 773
(b) Township St. Francois Primary Registration District No. 6018A
(c) City Near Farmington (d) Street No. State Hospital No. 4 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

420 Hettie Frances Boulch.
(a) Residence, No. Goodwater, Mo. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF George Wm. Boulch

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-7-1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
56 2 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Goodwater, Missouri

13. NAME James O. Scott.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington County Missouri

15. MAIDEN NAME Louisa Jane Payne

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington County Missouri

17. INFORMANT (ADDRESS) Records of State Hospt. #4 Farmington, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Indian Creek DATE 5/28 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) C. L. Sparks, Potosi, Mo.

20. FILED June 6 1939 T. J. Robinson Local Registrar. 699 (Address) Farmington, Mo.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-27 1939

22. I HEREBY CERTIFY, That I attended deceased from 4-17 1939, to 5-27 1939

I last saw h. or alive on 5-27 1939. Death is said to have occurred on the date stated above, at 11:50 a.m.
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis with Hypertrophy, Hypertension and mild Debridement
Cerebral Obstruction (Sudden Death)
Date of onset 5/21/39

Other contributory causes of importance: Arteriosclerosis, generalized
marked
Psychosis with Cerebral Arteriosclerosis Sept 1937

Name of operation None Date of
What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) C. C. Ault / M. D.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

not embalmed..... Registered Apprentice No.....
working under my personal supervision.

Signed *C. L. Sparks*.....
Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.