

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.

Lawrence C. Coster
Blytheville, Mo.

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

2490
Do not use this space.

1. PLACE OF DEATH

(a) County Harrison Registration District No. 335
 (b) Township Colfax Primary Registration District No. 5469
 (c) City New Windsor (d) Street No. _____ 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 HARRISON BOYER

(a) Residence, No. LAMOYI, IOWA St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Nancy Boyer
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 20, 1853
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 86 2 25
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. farmer
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/16 1940
 22. I HEREBY CERTIFY, That I attended deceased from 12/1 1939 to 1/16 1940
 I last saw him alive on 12/1 1939 Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Old Age
Flu
Date of onset _____
 Other contributory causes of importance: _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Scott County Iowa

FATHER 13. NAME Joseph C. Boyer
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER 15. MAIDEN NAME Mary L. De Roussie
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paris France

17. INFORMANT (ADDRESS) Essie B. Reed Blytheville, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Leon Iowa DATE Jan 18 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Frank B. Stewart Leon Iowa

20. FILED Jan 25, 1940 Mo. Wm. C. Bowls 915 (Address) Lamoni, Ia.
 Local Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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. no
 Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____ (Signed) Wm. C. Bowls, M. D.
915 (Address) Lamoni, Ia.

RECEIVED

District Health Officer No. 11,

District File Number

FEB 8

240-72
1940

Date Filed

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

Registered Apprentice No....., working under my personal supervision.

Signed *Frank S. Stewart*

Missouri Licensed Embalmer No. *3756*

P. O. Address *Leon Iowa*

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