

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

7612
Do not use this space.

1. PLACE OF DEATH *FILED MAR 12 1940* *2*
 (a) County Osage Registration District No. 0
 (b) Township Jefferson Primary Registration District No. _____ Registered No. _____
 (c) City _____ (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 *250* Mary C. Boyse
 (a) Residence, No. Bellevue R4 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 Female **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** single
 (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) October 29, 1941

7. AGE	YEARS	MONTHS	DAYS	IF LESS THAN 1 day, hrs. or min.
	98	2	18	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. retired housekeeper
 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 _____

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.
 13. NAME Samuel Boyse
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

MOTHER
 15. MAIDEN NAME Susan Johnson
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

17. INFORMANT H. L. Francis
 (ADDRESS) Belle, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Francis Cem. DATE Jan 20, 1940

19. FUNERAL DIRECTOR S. G. Licklider
 (ADDRESS) Belle, Mo.

20. FILED Mar 11 1940 Dr. Mrs. Susan Johnson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 17, 1940

22. I HEREBY CERTIFY, that I attended deceased from January 12, 1940 to Jan 15, 1940 saw her alive on Jan 15, 1940 Death is said to have occurred on the date stated above, at 6 p. m.
 The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis Date of onset _____
93C

Other contributory causes of importance: _____

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? _____ 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? _____
 If so, specify _____
 (Signed) Charles Leach, M. D.
 (Address) Belle Mo #3

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.

STATE OF TEXAS
DEPARTMENT OF HEALTH
DIVISION OF HEALTH SERVICES
EMBALMERS

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No..... or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **7612**

Registration District No. **643**

Primary Registration District No. **5852**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Osage**
(b) City or town **Jefferson**
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Osage**
(c) City or town **Belle Mo Route 1**
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Mary C Boyce**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years **98** Months **2** Days **18** If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Filed - April 12, 1940** **Wm L. Ingersoll**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **1**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature **Chas T Leach** (M. D. or other) _____

Address **Bland Mo** _____

SUPPLEMENTAL

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

