

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12077

Registration District No. 701

Primary Registration District No. 4422

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Bolivar Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7
(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 Polk
(c) City or town Bolivar
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch day 6
year 1940 hour _____ minute 10 P. M.

21. I hereby certify that I attended the deceased from 3-4-40
_____, 19____, to 3-6, 19____
that I last saw her alive on 3-6, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Stroke
cerebrovascular
meninges
Due to _____
Due to _____

Duration
2 1/2 hrs

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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? 630 (Specify type of place) _____
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
Address Bolivar Date signed 3-5-40

3. (a) PRINT FULL NAME Peggy Law Boyd, 420
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 21 - 1939
(Month) (Day) (Year)

8. AGE: Years _____ Months 8 Days 14 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Roma Boyd
13. Birthplace Pittsburg Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Dorothy Brown
15. Birthplace Oklahoma
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Roma Boyd
(b) Address Bolivar Mo.

17. (a) Interment (b) Date thereof 3-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Antioch

18. (a) Signature of funeral director Hutchinson & Co.
(b) Address Bolivar Mo.

19. (a) 3-17-40 (b) J. H. Robert
(Date received local registrar) (Registrar's signature)

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.

RECEIVED
District Health Officer No. 7
4-14-68
District File Number 4-13-40
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.....

Licensed Embalmer No.....

P. O. Address.....

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.