

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 36623

Registration District No. 875

Primary Registration District No. 6162

Registrar's No. 249

1. PLACE OF DEATH:

(a) County VERNON  
(b) City or town MEKADA  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
STATE HOSPITAL NO 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3  
(Specify whether years, months or days) 17 DAYS

8. (a) PRINT FULL NAME DAISY BOSEWELL

8. (b) If veteran, name war NONE 8. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife NONE 6. (c) Age of husband or wife if alive NONE years

7. Birth date of deceased MAY 12 1920  
(Month) (Day) (Year)

8. AGE: Years 20 Months 4 Days 23 If less than one day hr. min.

9. Birthplace POLK CO. MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation NONE

11. Industry or business NONE

MOTHER FATHER { 12. Name HARRY BOSWELL  
13. Birthplace FORTHY MISSOURI  
(City, town, or county) (State or foreign country)  
14. Maiden name INA CREECH  
15. Birthplace BRIGHTON MISSOURI  
(City, town, or county) (State or foreign country)

16. (a) Informant RECORDS STATE HOSP NO 3  
(b) Address NEVADA - MO.

17. (a) Burial (b) Date thereof Oct 13 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Slagle Cemetery

18. (a) Signature of funeral director Hutchinson  
(b) Address Bellevue, Mo.

19. (a) 10-11-40 (b) Allen V. Hoyle  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County POLK  
(c) City or town DUNNEGAN (RURAL)  
(If outside city or town limits, write "RURAL")  
(d) Street No. ROUTE No. 2  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? USA years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11  
year 1940 hour 9:30 minute A M.

21. I hereby certify that I attended the deceased from SEPT 24, 1940, to Oct 11, 1940

that I last saw her alive on Oct 11, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death CONVULSIONS  
Duration 15 DAYS  
AT INTERVAL

Due to MENINGO-VASCULAR LES

Due to 34

Other conditions MENTAL DEFICIENCY  
(Include pregnancy within 3 months of death)

Major findings: Of operations NONE  
Of autopsy NONE  
PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: NO

(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 \_\_\_\_\_

28. Signature Paul L. Barone (M. D. or other) M.D.

Address State HOSP NO 3 Date signed Oct 11 1940

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

RECEIVED

District Health Officer No. 7,

District File Number 11-10-151B

Date Filed 11-4-40

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**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.**