S. No. 2
—11-10-39
5-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN -7 1943

Registration District No. 366

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6244

State File No. 42265

Registrar's No. 66

1. PLACE OF DEATH:
(a) County: Washington
(b) City or town: Tiff Union Twp
(If outside city or town limits, write "RURAL" and name of township)
(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 years, months or days)
In this community: Tiff.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Washington
(c) City or town: Tiff.
(If outside city or town limits write "RURAL")
(d) Street No.: Tiff
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: SIMON T. BOYER
3. (b) If veteran, name war: ____
3. (c) Social Security No.: ____
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: ____
6. (c) Age of husband or wife if alive: ____ years
7. Birth date of deceased: June (Month) 23 (Day) 1932 (Year)

8. AGE: Years 10 | Months 1 | Days 30 | If less than one day ____ hr. ____ min.

9. Birthplace: Tiff. (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation: Child.
11. Industry or business: ____
FATHER
12. Name: Joseph Gaston Boyer
13. Birthplace: Tiff (City, town, or county) Mo 0 (State or foreign country)
MOTHER
14. Maiden name: Mary M. Boyer
15. Birthplace: Tiff (City, town, or county) Mo 0 (State or foreign country)
16. (a) Informant: Mrs Mary M Boyer
(b) Address: Tiff Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8 (Month) 23 (Day) 194 (Year)
(c) Place: burial or cremation: Tiff Mo.
18. (a) Signature of funeral director: Raymond J. Mohn
(b) Address: De Soto Mo.
19. (a) 12-11-1942 (Date received local registrar) (b) Joseph L. Thurman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21 year 1942 hour 5 minute 30 A.M.
21. I hereby certify that I attended the deceased from Aug 21, 1942 to Aug 21, 1942 that I last saw him alive on Aug 21, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Septicemia	3 day
Due to: Streptococcus infection	
Due to: Nail puncture wound	7 days
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): 110
(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: J. P. Angelos (M. D. or other) DO
Address: De Soto, Mo Date signed 8-21-42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 143-15-67

Date Filed 1-6-43

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 Daniel E. Mahn

Licensed Embalmer No. 3783

P. O. Address DeSoto, Mo.

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.