

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5787

State File No. _____

FILED MAR 11 1943
Registration District No. 38

Primary Registration District No. 3-0-0-6-5120

Registrar's No. 35

1. PLACE OF DEATH:

(a) County Boone
(b) City or town Rural
(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 _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas (b) County _____
(c) City or town Near Mineral Wells
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME RALPH RAYMOND BOYVEY

3. (b) If veteran, name war None 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

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

7. Birth date of deceased 7 - 17 - 1914
(Month) (Day) (Year)

8. AGE: Years 28 Months 6 Days 28
If less than one day _____ hr. _____ min.

9. Birthplace Sioux City / Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Flyer in U.S. Army Air Corp

11. Industry or business _____

12. Name Mike Boyvey

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

14. Maiden name Hulda Sandberg

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

16. (a) Informant Lt. H. Allen Benz

(b) Address St. Joseph, Missouri

17. (a) Removal (b) Date thereof 2-16-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Des Moines, Iowa

18. (a) Signature of funeral director Parkinson & Service

(b) Address Columbia, Mo.

19. (a) Feb 16 '43 (b) E. Christy Barber
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 15
year 1943 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 Acoplane Accident

Due to Motor Failure

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

Major findings: Of operations _____

Of autopsy (none)

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) Accident
(b) Date of occurrence _____
(c) Where did injury occur? near St. Louis, Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature Thos. J. Madson (M.D. or other) _____
Address Columbia, Mo Date signed 2/16/43

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

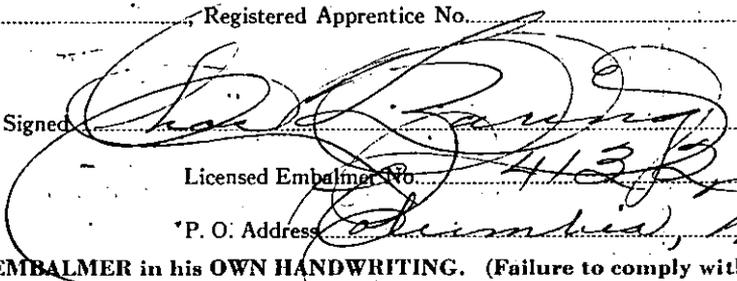
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STATEMENT BY LICENSED EMBALMER

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. 4132

* P. O. Address Columbia, S.C.

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, fact should be so stated above.