

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3759

FILED NOV 18 1943

Registration District No. 3000

Primary Registration District No. 3000

Registrar's No. 258

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Kirksville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Grim-Smith Hospital & Clinic  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days (Specify whether  
In this community 6 years 0 (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME Georgia Boley

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Married  
6. (b) Name of husband or wife Richard Boley 6. (c) Age of husband or wife if alive 20 years  
7. Birth date of deceased Oct. 10 1925  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
17 11 26 hr. min.

9. Birthplace Milan 0 Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business

12. Name Clarence Wheeler  
13. Birthplace Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Pearl Clark  
15. Birthplace Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Pearl Wheeler

(b) Address Kirksville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/43  
(Month) (Day) (Year)

(c) Place: burial or cremation Milan, Missouri

18. (a) Signature of funeral director Dee Riley

(b) Address Kirksville, Mo.

19. (a) 10/11/43 (Date received local registrar) (b) Mrs. J. W. Warner (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair  
(c) City or town Kirksville  
(If outside city or town limits, write "RURAL")  
(d) Street No. 507 West Illinois  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 6  
year 1943 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from October 3 1943 to October 6 1943;  
that I last saw her alive on October 6 1943;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Broken neck with paralysis Cardiac failure hypertension (107)  
Due to 1700  
Due to 22

Other conditions (Includes pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

3 days

2 days

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 October 3, 1943

(c) Where did injury occur? Near New Cambria, Missouri  
(City or town) (County) (State)

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

While at work? No. (Specify type of place) (e) Means of injury Car accident

23. Signature George E. Grim (M. D. or other)

Address Kirksville, Mo. Date signed 10-7-43

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

MOTHER, FATHER

RECEIVED

District Health Officer No. 10

District File Number 11-43-1846

Date Filed NOV 16 1949

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.....

*Mrs. Laura Riley*

Licensed Embalmer No.....

*3907*

P. O. Address.....

*Kingsville 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, fact should be so stated above.