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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8063**
Registrar's No. **47**

FILED MAR 13 1944
Registration District No. **2921**

Primary Registration District No. **3056**

1. PLACE OF DEATH:
(a) County **Moberly Randolph**
(b) City or town **Moberly**
(c) Name of hospital or institution: **125 S 5th**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **30 years** (Specify whether years, months or days)

USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Randolph**
(c) City or town **Moberly**
(If outside city or town limits, write "RURAL")
(d) Street No. **125 S 5th**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Charles A. Boyne**
3. (b) If veteran, name war **✓**
3. (c) Social Security No. **✓**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Feb** day **5**
year **1944** hour **2:30 pm** minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____, to **now**, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex **M.** 5. Color or race **W.**
6. (a) Single, widowed, married, divorced **✓ 0**

Immediate cause of death
Natural Undetermined
Likely Coronary Thrombosis
Sudden Death
Due to _____
Due to **Coroners care**

6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **Jan 9-1924**
(Month) (Day) (Year)

8. AGE: Years **70** Months **0** Days **24**
If less than one day _____ hr. _____ min.

Duration
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: **94a**
Of operations _____
Of autopsy _____

9. Birthplace **Ill**
(City, town, or county) (State or foreign country)
10. Usual occupation **Farmer**

MOTHER FATHER
11. Industry or business _____
12. Name **Joseph S Boyne**
13. Birthplace **K. I. I**
(City, town, or county) (State or foreign country)
14. Maiden name **Prisca Thomas**
15. Birthplace **Mo. O**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **James Boyne**
(b) Address **Moberly Mo**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **2-8-1944**
(Month) (Day) (Year)
(c) Place: burial or cremation **Trapperville**
18. (a) Signature of funeral director **W. H. Hopper**
(b) Address **Blanchard Mo**
19. (a) **2-16-44** (Date received local registrar) (b) **Orma Nave** (Registrar's signature)

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 _____ (Specify type of place) (e) Means of injury **3**
Coroner
23. Signature **W. H. Hopper** (M. D. or other)
Address **Moberly** Date signed **2/9/44**

Dr Griffiths

James D. S.

RECEIVED

District Health Officer No. 10

District File Number 3-44-613

Date Filed MAR 10 1944

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..... *Louis C. Hopper*

Licensed Embalmer No. 4761

P. O. Address..... *Clarence, 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.