

No. 2
2-43
17-39
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FILED APR 13 1944

State File No. _____

Registration District No. 297

Primary Registration District No. 6021

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Ray Snake Grove Twp

(b) City or town State Rural R No 1
(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 _____)

In this community _____ (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County 89

(c) City or town _____ (If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____ 0

3. (a) PRINT FULL NAME Rose Miller Boyer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6th year 1944 hour 12:25 minute A. M.

21. I hereby certify that I attended the deceased from April 5, 1944, to April 6, 1944, that I last saw him alive on April 6, 1944, and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased: May 19 1872
(Month) (Day) (Year)

Immediate cause of death Acute Cardiac Dilatation Duration 1 hr.

Due to Circulatory Failure 2 hrs.

Due to Influenza unknown

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

8. AGE: Years Months Days If less than one day

72 11 13 hr. min.

9. Birthplace Rockingham Co Virginia
(City, town or county) (State or foreign country)

Major findings: Of operations ZZA

Of autopsy _____

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

10. Usual occupation Housekeeper

11. Industry or business George Miller

12. Name George Miller

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

14. Maiden name Ann Heavner

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

16. (a) Informant: Etha Broughton

(b) Address Broyner

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr-8-44
(Month) (Day) (Year)

(c) Place: burial or cremation Wakonda Cem

18. (a) Signature of funeral director John Kneppchuld

(b) Address Hardin mo

19. (a) April 1944 (b) Thos. H. Shippert
(Date received local registrar) (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? _____

(Specify type of place) _____

While at work? _____ (e) Means of Injury _____

23. Signature John R. Crank (M.D. or other) Dr.

Address Broyner, Mo Date signed 4-6-44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 4-12-44

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 me

....., Registered Apprentice No.....
working under my personal supervision.

Signature John W. Krupchick

Licensed Embalmer No. 2789

P. O. Address Hardin, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April
Registrar's No. 5

Registration District No. 297 Primary Registration District No. 6021

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

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Rural Hayes Grove
(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)

In this community Do Not Know
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County RAY

(c) City or town STEL RURAL
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____
(Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Rose Miller Boyer

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 19 1944
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days _____
(If less than one day)

9. Birthplace Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4/1-1944 (b) Mrs. Charles Shipp
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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) _____

(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) (c) Means of injury

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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