

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

**1. PLACE OF DEATH:** *Marion*  
(a) County *Marion*  
(b) City or town *Belle, Mo.*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: *Residence of Daughter 1*  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution *5 days* (Specify whether years, months or days)  
In this community *5 days*

**3. (a) PRINT FULL NAME** *Jane Almona Boyce*  
**3. (b) If veteran name war** *no* **3. (c) Social Security No.** *none*

**4. Sex** *Female* **5. Color or race** *White*  
**6. (a) Name of husband or wife** *John Allen Boyce*  
**6. (b) Birth date of deceased** *Feb. 23, 1878*  
(Month) (Day) (Year)

**8. AGE:** Years *66* Months *10* Days *13* If less than one day hr. min.

**9. Birthplace** *Gasconade County, Mo.*  
(City, town, or county) (State or foreign country)

**10. Usual occupation** *Housework*

**11. Industry or business** *Own Home*

**MOTHER, FATHER**  
**12. Name** *Rush Matthews*  
**13. Birthplace** *Unknown Unknown*  
(City, town, or county) (State or foreign country)  
**14. Maiden name** *Mahinda Crider*  
**15. Birthplace** *Unknown Unknown*  
(City, town, or county) (State or foreign country)

**16. (a) Informant** *Mr. W.O. Boyce*  
**(b) Address** *Belle, Mo.*

**17. (a) Burial** *Burial* **(b) Date thereof** *Jan 7, 1945*  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** *Union Cem. Bland, Mo.*

**18. (a) Signature of funeral director** *Wesmann Funeral Home*  
**(b) Address** *Bland, Mo.*

**19. (a) 1/10/45** **(b) Emma Bassett**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State *Mo.* (b) County *Gasconade*  
(c) City or town *Bland*  
(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

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month *Jan* day *5* year *1945* hour *eleven* minute *30 A.M.*  
**21. I hereby certify that I attended the deceased from** *Jan 15, 1944* to *Jan 5, 1945*  
that I last saw her alive on *Dec 28, 1945* and that death occurred on the date and hour stated above.

Immediate cause of death *Coronary occlusion*  
Due to *Chronic Hypertension 3 yrs.*

Due to  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations  
Of autopsy

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)  
(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** *R. H. DeJouhalet* **Date signed** *1/15/45*  
Address *Belle, Mo.*

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 3-8-45

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.

Signed: Robert M Murray  
Licensed Embalmer No. 3749  
P. O. Address Owensville, 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.