

3. No. 2  
A-5-43  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26186

State File No. \_\_\_\_\_

FILED AUG 19 1946

Registration District No. 7 Primary Registration District No. 4020-5033 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Andrew

(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community 20 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Andrew

(c) City or town Rural

(d) Street No. 3 miles W. of Martinsburg

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME BEULAH LEE BOICOURT.

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27<sup>th</sup> year 1946 hour 5:20 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from August 24 1945 to July 27 1946

that I last saw her alive on July 22 1946 and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife A. E. Boicourt

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Aug 30 1891

Immediate cause of death Cerebral Hemorrhage (left) with Rb. Hemiplegia Duration 2 mos

Due to Chronic Hypertension & Chronic Nephritis years

Due to Hypertension years

Other conditions Verrucae Ueius 4 yrs

8. AGE: Years 54 Months 8 Days 27 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Martinsburg Mo

10. Usual occupation Housewife

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy A-3 B

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name M. J. Deardorff

13. Birthplace Calaway Co Mo

14. Maiden name Deardorff

15. Birthplace Calaway Co Mo

16. (a) Informant Evelyn Deardorff

(b) Address 1629 Western Ave. Mo.

17. (a) Burial (b) Date thereof July 29 1946

(c) Place: burial or cremation Burial - B. B. Carter

18. (a) Signature of funeral director E. T. Andersen

(b) Address Wellsville Mo

19. (a) July 30 46 (b) Mrs. Joe Carter

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 \_\_\_\_\_

23. Signature E. T. Andersen (M. D. or other) M.D.

Address Martinsburg City Mo Date signed 7/26/46

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

RECEIVED  
District Health Officer No. 10  
District File Number 8-46-1529  
Date Filed AUG 1 1946

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

working under my personal supervision.

Signed

Registered Apprentice No.  
Licensed Embalmer No. 3059

P. O. Address Willsville 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.