

S. No. 2  
A-8-43  
5-17-39  
PI X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **18244**  
Registrar's No. **100**

FILED JUN 2 1947

Registration District No. **257**

Primary Registration District No. **3048**

1. PLACE OF DEATH:  
(a) County **Nodaway**  
(b) City or town **Burlington Jct. Maryland**  
(c) Name of hospital or institution: **St Francis Hospital**  
(d) Length of stay: In hospital or institution **5 weeks**  
In this community **50 yrs**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Nodaway**  
(c) City or town **Burlington Jct**  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? **No**

3. (a) PRINT FULL NAME **Gerald Boyer**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **M** 5. Color or race **W**  
6. (b) Name of husband or wife **Beulah Boyer**  
7. Birth date of deceased **Sept 14 1875**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **May** day **14** year **1947** hour **5:00** minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from **Feb - 7** 19**47**, to **May 14** 19**47**  
that I last saw him live on **May 14** 19**47** and that death occurred on the date and hour stated above.

8. AGE: Years **71** Months **8** Days **0** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death **Cerebral hemorrhage**  
**Coronary sclerosis**  
Due to **Coronary occlusion**  
Due to \_\_\_\_\_

9. Birthplace **Stryker Ohio**  
10. Usual occupation **Farmer**

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations **of BP**  
Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
12. Name **David Boyer**  
13. Birthplace **Huntington Co Penn**  
14. Maiden name **Harriett Schaffer**  
15. Birthplace **Montgomery Co Ohio**

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

16. (a) Informant **Mrs Beulah Boyer**  
(b) Address **Burlington Jct. Mo**  
17. (a) **Burial** (b) Date thereof **May 16, 1947**  
(c) Place: burial or cremation **Ohio Cemetery**

(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature **B. F. Beulah** (M. D. or other) \_\_\_\_\_  
Address **Burlington Jct. Mo** Date signed **5/17/47**

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address **Burlington Mo**  
19. (a) **5/17/47** (b) **Beaso Holt**

(Licensed Embalmer's Statement on Reverse Side)

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

74  
1  
2

Duration  
**5 wks**  
**3**  
**3 yrs**  
  
PHYSICIAN  
  
Underline the cause to which death should be charged statistically.

DISTRICT HEALTH OFFICE  
Cameron, Mo.

JUN 10 1947

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.....

Licensed Embalmer No. 2968

P. O. Address. Bur. J. M.

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.