

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25475**
Registrar's No. **895**

FILED AUG 30 1948

Registration District No. **42**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 weeks** (Specify whether
In this community **35 years** years, months or days)

3. (a) PRINT FULL NAME **Amanda Belle Boyer**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **Lewis C. Boyer** 6. (c) Age of husband or wife if alive **14** years

7. Birth date of deceased **January 14 1873**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
75	7	8		hr. min.

9. Birthplace **Wyane County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **At home.**

11. Industry or business

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Clay R. Boyer**

(b) Address **Swift & Co. Kansas City, Mo.**

17. (a) **Burial** (b) Date thereof **Aug. 25, 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Walter Meierhoffer**

(b) Address **1946 Colhoun St., St. Joseph, Mo.**

19. (a) **Aug. 25, 1948** (b) **E. G. Jenkins**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. **713 Robidoux Street**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **22nd**
year **1948** hour **8** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **July 1, 1948** to **Aug 8, 1948**
that I last saw her alive on **Aug 3, 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **9 hrs**

Due to **arterio scl. gen.**

Due to **hypertension.**

Other conditions **Old myocardial**
(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) (2) Means of injury

23. Signature **Frank Handegard** (M. D. or other)

Address **670 Homer** Date signed **8/23/48**

St. Joseph, Mo.

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

070

8478

OCT 1

SEP 10 1948

DEC 11 1948

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 *Albert E. Harrington*

Licensed Embalmer No. 3258 Missouri

P. O. Address St. Joseph, 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.