

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43514**

FILED JAN 5 1950
REG. DIST. NO. **360** PRIMARY REG. DIST. NO. **6625** Registrar's No. **193**

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

1. PLACE OF DEATH a. COUNTY Vermon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Janey	
b. CITY (If outside corporate limits, write RURAL and give township) Washington Twp		c. LENGTH OF STAY (In this place) 1 M. 7 D.	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital # 3-2		c. CITY (If outside corporate limits, write RURAL and give township) Bradleyville - Rural	
d. STREET ADDRESS Rural			
3. NAME OF DECEASED (Type or Print) a. (First) Gracie b. (Middle) - c. (Last) Boyd		4. DATE OF DEATH (Month) (Day) (Year) 12-27-1949	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 2-8-1908
9. AGE (In years last birthday) 41		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). house wife	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? United States			
13a. FATHER'S NAME Thomas Campbell		13b. MOTHER'S MAIDEN NAME Sarah Speer	
14. NAME OF HUSBAND OR WIFE DTC.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. DTC.	
17. INFORMANT'S SIGNATURE OR NAME Records- State Hosp. No. 3		ADDRESS Washington	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Pneumonia INTERVAL BETWEEN ONSET AND DEATH 2 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Dementia Praecox Catatonic Type Severe DUE TO (c) - II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 3007	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY! YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12-27-1949		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11:20 , 1949, to 12-27 , 1949, that I last saw the deceased alive on 12-27 , 1949, and that death occurred at 10:30 P m. , from the causes and on the date stated above.			
23a. SIGNATURE J.R. Bunch M.D.		23b. ADDRESS State Hospital # 3	
23c. DATE SIGNED 12-27-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12/29/49	
24c. NAME OF CEMETERY OR CREMATORY unknown		24d. LOCATION (City, town, or county) (State) Bronson, Mo	
DATE REC'D BY LOCAL REG. Dec. 29, 1949		REGISTRAR'S SIGNATURE Walter H. Janey	
25. FUNERAL DIRECTOR'S SIGNATURE Allen E. Hays		ADDRESS Nevada, Mo	

APR 27 1950

RECEIVED

District Health Officer No. 71

District File Number 1249-1550

Date Filed 1-4-57

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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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Bert B. Bennett

Licensed Embalmer No. 4656

P. O. Address Merada, 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.