

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24026**

FILED JUL 24 1950

0644

BIRTH NO. _____		REG. DIST. NO. 209		PRIMARY REG. DIST. NO. 3043		Registrar's No. 248	
1. PLACE OF DEATH a. COUNTY Marion				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Pike			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal		c. LENGTH OF STAY (in this place) 10 Days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RFD # 1 Buffalo Twnshp.		0830	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Elizabeth's Hospital				d. STREET ADDRESS (If rural, give location) Louisiana, Missouri			
3. NAME OF DECEASED (Type or Print) a. (First) Harry b. (Middle) ----- c. (Last) Boullear			4. DATE OF DEATH (Month) (Day) (Year) July 13, 1950				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Dec. 17, 1872		9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Days 6	IF UNDER 4 HRS. Hours Min. 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Hannibal, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Antone Boullear		13b. MOTHER'S MAIDEN NAME Elizabeth Sell		14. NAME OF HUSBAND OR WIFE -----			
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. -----		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clarence Boullear, Hannibal, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Auricular fibrillation		ANTECEDENT CAUSES Myocardial failure				about 6 months.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) -----					
		DUE TO (c) -----					
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.				4331	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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) (Min.)		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:50 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) J. E. Sutzman, M.D.				23b. ADDRESS Hannibal Mo.		23c. DATE SIGNED 7-14-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7/15/50	24c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		24d. LOCATION (City, town, or county) (State) Louisiana, Missouri		
DATE REC'D BY LOCAL REG. 7/18/50		REGISTRAR'S SIGNATURE Dr. E. M. Kuecke, Deputy		FUNERAL DIRECTOR'S SIGNATURE George O. Wagner		ADDRESS Louisiana, Mo.	

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

RECEIVED JUL 20 1950
MARION CO. HEALTH DEPT.
DATE FILED JUL 22 1950

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.....
Student Embalmer

Signed George O. Stagner
Student Embalmer No. _____
Licensed Embalmer No. 3773
P. O. Address Louisiana, 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.