

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32970**
Registrar's No. **87**

FILED NOV 5 1951

REG. DIST. NO. **75** PRIMARY REG. DIST. NO. **8015**

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

BIRTH NO. _____		REG. DIST. NO. 75		PRIMARY REG. DIST. NO. 8015		Registrar's No. 87	
1. PLACE OF DEATH a. COUNTY Canton				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY D. KALB			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cameron		c. LENGTH OF STAY (In this place) 3 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fairport		8320	
d. FULL NAME OF HOSPITAL OR INSTITUTION West Second St.				d. STREET ADDRESS (If rural, give location) Fairport, Missouri!			
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM		b. (Middle) M.		c. (Last) Boal		4. DATE OF DEATH (Month) (Day) (Year) Oct 22 1951	
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH May 20-1894	
9. AGE (In years - last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Robert Boal		13b. MOTHER'S MAIDEN NAME Hattie Oyler		14. NAME OF HUSBAND OR WIFE ONA Boal			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 520-01-9593		17. INFORMANT'S SIGNATURE OR NAME Paul Boal ADDRESS Cameron			
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) Acute Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Previous Small Arterial Occlusions DUE TO (c) Generalized Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 5 min.	
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)		4201	
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 Oct 19, 1951 , to Oct 22, 1951 , that I last saw the deceased alive on Oct. 22, 1951 , and that death occurred at 12:00 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE W. Bloom (Degree or title)				23b. ADDRESS Cameron, Mo.		23c. DATE SIGNED 10-23-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-25-51		24c. NAME OF CEMETERY OR CREMATORY Leola S. Sloop		24d. LOCATION (City, town, or county) (State) Leola S. Sloop, Wayne, Mo.	
DATE REC'D BY LOCAL REG. 10-25-51		REGISTRAR'S SIGNATURE Wendell J. Mosley		394 MINERAL DIRECTOR'S SIGNATURE Paul James		ADDRESS Cameron	



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 Robert F. Paland

Licensed Embalmer No. 4217

P. O. Address 222 West 7th St
Cameron Ind

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.