

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22266**

FILED AUG 2 - 1954

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008** Registrar's No. **220**

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

1. PLACE OF DEATH a. COUNTY Calloway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Moniteau	
b. CITY (If outside corporate limits, write RURAL and give township) Fulton Mo		c. LENGTH OF STAY in this place 25 years	c. CITY OR TOWN Tipton
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital No 1		e. STREET ADDRESS (If rural, give location) 0681	
3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) - c. (Last) BOYLES		4. DATE OF DEATH (Month) (Day) (Year) 7-25 25 54	
5. SEX M	6. COLOR OR RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 3-22-1881
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Days	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY - DK	11. BIRTHPLACE (City and State or Foreign Country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S. Id.		13a. FATHER'S NAME DK	
13b. MOTHER'S MAIDEN NAME DK		14. NAME OF HUSBAND OR WIFE DK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) DK		16. SOCIAL SECURITY NO. DK	
17. INFORMANT'S SIGNATURE OR NAME John B Jacob Heiney Jr - 2		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary heart disease		INTERVAL BETWEEN ONSET AND DEATH 2	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		II. ANTECEDENT CAUSES	
DUE TO (b) General atherosclerosis		DUE TO (c) Syphilis of brain	
III. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. -	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? 026 X		YES <input type="checkbox"/> NO <input 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) (Minute)	
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 9-17 1953 , to 7-25 1954 , that I last saw the deceased alive on 7-26 1954 and that death occurred at 11 a. m. , from the causes and on the date stated above.			
23a. SIGNATURE D. Nichols by [Signature] (Degree or title)		23b. ADDRESS State Hospital 7-25 Fulton Mo	
23c. DATE SIGNED		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 7-27-54		24c. NAME OF CEMETERY OR CREMATORY Washington Road Columbia Mo	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE J. O. Roberts ADDRESS Columbia Mo	
DATE REC'D. BY LOCAL REG. July 27-1954		REGISTRAR'S SIGNATURE Martha Lawrence	

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be stated above.