

FILED MAY 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14508**

BIRTH NO. _____		REG. DIST. NO. 1		PRIMARY REG. DIST. NO. 3000		Registrar's No. 128	
1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Adair			
b. CITY (If outside corporate limits, write RURAL and give township) KIRKSVILLE		c. LENGTH OF STAY (In this place) 2 wks.		c. CITY (If outside corporate limits, write RURAL and give township) KIRKSVILLE			
d. FULL NAME OF HOSPITAL OR INSTITUTION Community Nursing Home #1				d. STREET ADDRESS (If rural, give location) 716 N. ELSON			
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE		b. (Middle) W.		c. (Last) BOZARTH		4. DATE OF DEATH (Month) (Day) (Year) 5 14 1955	
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER		8. DATE OF BIRTH Aug. 17, 1873	
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Adair county, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME James M. Bozarth		13b. MOTHER'S MAIDEN NAME Rachael McPhetridge		14. NAME OF HUSBAND OR WIFE Sina Coy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No X		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS George Daniels, Novinger, Mo.			
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medullary Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cause Unknown DUE TO (c) _____ 11. 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? 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)	
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 Apr 29 1955 to MAY 14, 1955 , that I last saw the deceased alive on MAY 13, 1955 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) David M. Boone MD				23b. ADDRESS Kirksville MO		23c. DATE SIGNED 5-15-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5/16/55		24c. NAME OF CEMETERY OR CREMATORY Ringo Point		24d. LOCATION (City, town, or county) (State) Adair county, Mo.	
DATE REC'D BY LOCAL REG. 5-16-55		REGISTRAR'S SIGNATURE Kate Lambert		25. FUNERAL DIRECTOR'S SIGNATURE Paul M. T. ...		ADDRESS Kirksville, Mo.	

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

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

George W. Davelle

Licensed Embalmer No. _____

4799

P. O. Address _____

Wicksville, Md

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.