

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42069

State File No. \_\_\_\_\_

FILED JAN 7 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 179 PRIMARY REG. DIST. NO. 5667 Registrar's No. 18

1. PLACE OF DEATH a. COUNTY <u>LINCOLN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Mo.</u> b. COUNTY <u>Schultz</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>TROY (Rural)</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>O'Fallon</u>	
c. LENGTH OF STAY (in this place) <u>3 days</u>		d. STREET ADDRESS (If rural, give location) <u>RFA # 2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lincoln Co. Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>VIRGINIA</u> b. (Middle) <u>JENNIE</u> c. (Last) <u>BOFFA</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 29 1956</u>		
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH <u>Nov 8 - 1879</u>		9. AGE (In years last birthday) <u>77</u>		IF UNDER 1 YEAR: Months _____ Days _____	
IF UNDER 1 YEAR: Hours _____ Mins. _____		IF UNDER 1 HR. Hours _____ Mins. _____		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Charles Co.</u>	

13a. FATHER'S NAME <u>John Boffa</u>		13b. MOTHER'S MAIDEN NAME <u>Not known</u>		14. NAME OF HUSBAND OR WIFE _____	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Bernard M. Mangier</u> ADDRESS <u>O'Fallon Mo.</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Cerebral Thrombosis</u>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES DUE TO (b) <u>Arteriosclerosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) <u>Senility</u>			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Uremia</u>			

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) <u>332x</u>	
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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 _____	
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22. I hereby certify that I attended the deceased from Dec 26, 1956, to Dec 28, 1956, that I last saw the deceased alive on Dec 28, 1956, and that death occurred at 7:15 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Harold A. Mangier D.O.</u>		23b. ADDRESS <u>O'Fallon Mo.</u>		23c. DATE SIGNED <u>Dec 29 1956</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>Dec. 31 - 1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cem.</u>	
				24d. LOCATION (City, town, or county) (State) <u>St Paul Mo.</u>	

DATE REC'D BY LOCAL REG. <u>Jan 2 - 1957</u>		REGISTRAR'S SIGNATURE <u>Emma B. Riddle</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. K. Kelly</u> ADDRESS <u>O'Fallon Mo.</u>	
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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 \_\_\_\_\_

*E. K. Kelly*

Licensed Embalmer No. \_\_\_\_\_

*877*

P. O. Address \_\_\_\_\_

*Dallow 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.