

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5907

FILED FEB 20 1957

STATE FILE NUMBER

Registration District No. 311 Primary Registration District No. 4456 Registrar's No. 4

Health, Welfare  
Public  
Service

300 0930  
7-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St Clair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Appleton City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Montrose</u> <sup>0420</sup> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ellett Hospital 21days</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>RR #1</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise Carolin Boden</u>			4. DATE OF DEATH Month Day Year <u>2-11-1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-1892</u>
9. AGE (In years last birthday) <u>65</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>	11. BIRTHPLACE (City and state or county) <u>Montrose Mo</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Firsick</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kirn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>499-42-8822</u>	17. INFORMANT Address <u>John Boden Montrose Mo</u>
18. CAUSE OF DEATH [Enter only one cause per time for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Fracture of femoral neck 23 Jan '57</u> DUE TO (c) <u>9030</u> PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>20</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell while working at home</u>		
20c. TIME OF INJURY Hour Month, Day, Year <u>Jan 23 1957</u>	20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>at home</u>	20f. CITY, TOWN, OR LOCATION COUNTY <u>Henry</u> STATE <u>Mo</u>		
21. I attended the deceased from <u>23 Jan 57</u> to <u>11 Feb 57</u> and last saw her <u>alive on 11 Feb 57</u> Death occurred at <u>9:30 a m</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>W. L. Lillard</u> (Degree or title)		22b. ADDRESS <u>Appleton City</u>	
22c. DATE SIGNED <u>11 Feb 57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-14-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>	23d. LOCATION (City, town, or county) (State) <u>Montrose Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Sickman-Dunning Clinton Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Feb. 14, 1957</u>	
		26. REGISTRAR'S SIGNATURE <u>Oles Abney</u>	

(Licensed Embalmer's Statement on Reverse Side)

FEB 19 1958

**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..... *Robert L. Dunning*

Licensed Embalmer No. *H. 4*

P. O. Address *Clinton*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**: (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 so stated above.