

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026617
STATE FILE NUMBER

FILED JUL 22 1958 Registration District No. 297 Primary Registration District No. 6021 Registrar's No. 70

1. PLACE OF DEATH a. COUNTY Ray		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY May	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Grape Grove Twn. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Grape Grove Twn. 0890 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Own home		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in 1b 21 yrs.			
3. NAME OF DECEASED (Type or print) First MIDDLE Last CYNTHIA EUNICE HALE			4. DATE OF DEATH Month Day Year July 5, 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1872
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		9b. AGE (In years last birthday) 86yrs.	9c. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) Ray County, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Boyer		14. MOTHER'S MAIDEN NAME Cynthia Thompson	
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. -	
17. INFORMANT Mrs Bertha Robb Kansas City, Mo.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>many years</u> <u>many years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Cerebral Arteriosclerosis</u>	
		DUE TO (c) <u>Generalized Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Rheumatoid Arthritis 332X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

20a. ACCIDENT <input 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.) -		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input 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.) -	20f. CITY, TOWN, OR LOCATION -	COUNTY -	STATE -
21. I attended the deceased from <u>July 1947</u> to <u>July 5, 1958</u> and last saw her <u>alive</u> on <u>July 4, 1958</u> . Death occurred at <u>4:30 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>D. E. Goldberg M.D. MD</u>			22b. ADDRESS Braymer, Mo.		22c. DATE SIGNED 7-7-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 8, 1958	23c. NAME OF CEMETERY OR CREMATORY New Hope Cem.	23d. LOCATION (City, town, or county) (State) Braymer, Mo.
24. FUNERAL DIRECTOR MEAD-PITTS, A 7 M Braymer, Mo.		25. DATE RECD. BY LOCAL REG. 7-14-1958	26. REGISTRAR'S SIGNATURE Malcolm Jackson

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare
Public
Service
890
300
1-56

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

MEDICAL CERTIFICATION

FEB 18 1959

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 *Samuel F. Mead*

Licensed Embalmer No. 2801

P. O. Address Brainer, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.