

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039596

STATE FILE NUMBER

FILED NOV 17 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1079A

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> & COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Burge Hospital</u>		Length of stay in lb <u>50 yrs.</u>	0396 d. STREET ADDRESS (If outside, give location) <u>813 W. Madison</u> o
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>M.</u> Last <u>Boyle</u>			4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1878</u>
9. AGE (In years, last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>W. C. Boyle</u>	
13b. MOTHER'S MAIDEN NAME <u>Rachel Davis</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Ann Boyle (Dec.)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes) <input type="checkbox"/> (Unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT (Name) Address <u>Mrs. James Hitchell - Springfield, Mo.</u>
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>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</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)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Unknown</u> <u>Unknown</u>
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.) <u>4500</u>	
20c. TIME OF INJURY Hour <u>7:45</u> Month <u>Nov</u> , Day <u>7</u> , Year <u>1958</u> a.m. <u>pm</u>		20d. INJURY OCCURRED WHILE AT <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>Sept. 1958</u> to <u>Nov. 7, 1958</u> and last saw ^{her} him alive on <u>Nov. 7, 1958</u> Death occurred at <u>7:45 hr</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Albert P. Simpson, M.D.</u>		22b. ADDRESS <u>Springfield Med. Bldg., Springfield, Mo.</u>	
22c. DATE SIGNED <u>11-14-58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>11-10-'58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cem.</u>	
23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Rex Rainey - Springfield, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>11-14-58</u>		26. REGISTRAR'S SIGNATURE <u>Officer Melton</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

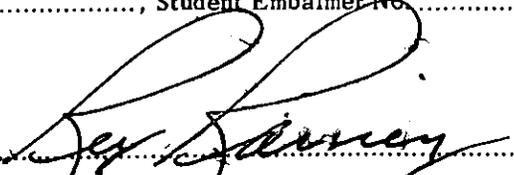
Secretary, coronator, etc.: must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

NOV 23 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  _____

Licensed Embalmer No. 3312
P. O. Address Springfield, 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.