Health,
Welfare
Public
Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-008783
STATE FILE NUMBER

FILED MAR 30 1959 Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 24

1. PLACE OF DEATH
a. COUNTY: Clinton
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Cameron — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Cameron Hosp — Length of stay in Ib: 5 hrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Clinton
c. CITY OR TOWN: Hemple — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Clyde Middle: — Last: Boyer
4. DATE OF DEATH: Month 3 Day 20 Year 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 14, 1873
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Hemple, Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Joseph Boyer
13b. MOTHER'S MAIDEN NAME: Not Known
14. NAME OF HUSBAND OR WIFE: Lulu Boyer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 496-42-0308
17. INFORMANT: Guy Boyer Address: Hemple, Mo.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ~~Acute~~ Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331X
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 3/20/59, to 3/20/59 and last saw her/him alive on 3/20/59
Death occurred at 11:35 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: E. T. Dwyer (Degree or title) DO
22b. ADDRESS: Stewartsville, Mo.
22c. DATE SIGNED: 3-21-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-23-59
23c. NAME OF CEMETERY OR CREMATORY: Keller Cemetery
23d. LOCATION (City, town, or county) (State): Clinton Co. Mo.

24. FUNERAL DIRECTOR: W.E. Summerfield ADDRESS: Stewartsville Mo
25. DATE RECD. BY LOCAL REG.: 3-24-59
26. REGISTRAR'S SIGNATURE: Francis D. Crawford

(Licensed Embalmer's Statement on Reverse Side)

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.

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 W. E. Summerfield

Licensed Embalmer No. 3007

P. O. Address Stewartsville

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.