

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012719

STATE FILE NUMBER

FILED APR 30 1959 Registration District No. 74 Primary Registration District No. 5294 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>CLINTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLINTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLINTON</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>LATHROP</u> <u>Mo. 250</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RFD 2</u>		Length of stay in lb <u>2 1/2 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>CLINTON TWP. RFD 2</u>
			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>AMANDA - BOYLES</u>			4. DATE OF DEATH Month Day Year <u>APRIL 25 1959</u>		
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 25 1865</u>	9. AGE (In years last birthday) <u>93</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>8 0 - -</u>	IF UNDER 24 HRS. Hours Min. <u>- -</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>SHELBYVILLE Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>DAVID BIXLER</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
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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>NO</u>	17. INFORMANT <u>C.E. BOYLES</u>	Address <u>LATHROP MO.</u>
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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>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
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)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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>4201</u>
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20c. TIME OF INJURY Hour Month, Day, Year <u>7:30 (p.m.) 4 25 59</u>
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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 <u>LATHROP</u>	COUNTY <u>CLINTON</u>	STATE <u>MO.</u>
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21. I attended the deceased from Jan 1958 to April 1959 and last saw her alive on 4-24-59
Death occurred at 7:30 p on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>David Williams, M.D., Coroner 3</u>	22b. ADDRESS <u>Lathrop, Mo.</u>	22c. DATE SIGNED <u>4-26-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NORRIS</u>	23d. LOCATION (City, town, or county) (State) <u>HENRY COUNTY MO.</u>
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24. FUNERAL DIRECTOR <u>SCHABERG FUNERAL HOME</u>	ADDRESS <u>CLINTON MISSOURI</u>	25. DATE RECD. BY LOCAL REG. <u>APRIL-26-59</u>	26. REGISTRAR'S SIGNATURE <u>Mary W Pearce</u>
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(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

MAY 22 1956

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 F. L. Schaefer

Licensed Embalmer No. 4513
P. O. Address Center Md

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.