

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024105

FILED VS AUG 11 1959

Registration District No. 32 Primary Registration District No. _____ Registrar's No. 51 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Bollinger</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bollinger</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lutesville</u>		Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>ZALMA</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location), HOSPITAL OR INSTITUTION <u>Bond Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Star Route 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Boyd</u> Last <u>Angel</u>				4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1959</u>			
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>8/1/1890</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>26</u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>
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>HOUSEWIFE</u>		11. BIRTHPLACE (City and state or country) <u>Bollinger County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>JOE MOORE</u>		13b. MOTHER'S MAIDEN NAME <u>Cynthia Elizabeth DUNN</u>		14. NAME OF HUSBAND OR WIFE <u>John Boyd Zelma, Mo.</u>			
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>NONE</u>		17. INFORMANT <u>John Boyd</u>		Address <u>Zelma, 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>Thrombosis</u> DUE TO (b) <u>Cardio vascular renal disease</u> <u>6 days.</u> DUE TO (c) <u>Atherosclerosis</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>		Month, Day, Year <u></u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>6/12/59</u> to <u>7/27/59</u> and last saw her alive on <u>7/27/59</u> Death occurred at <u>9:40 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>John H. Morgan M.D.</u>				22b. ADDRESS <u>Lutesville Mo</u>		22c. DATE SIGNED <u>7/31/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7/30/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BAKER CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>Lutesville, Missouri</u>			
24. FUNERAL DIRECTOR <u>Wm H. Morgan</u>		ADDRESS <u>Lutesville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8/6/59</u>		26. REGISTRAR'S SIGNATURE <u>Mr. Buford Crider</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm H. Morgan

Licensed Embalmer No. 4640

P. O. Address Adrian, MI

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con-
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.