

**JURISDICTION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS DEC 30 1959 70

'59 0 4 3 6 5 4

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. 74

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

3. NAME OF DECEASED (Type or print) <b>George I. Böley</b>	First Middle Last	4. DATE OF DEATH <b>Dec. 20, 1959</b>	Month Day Year
---------------------------------------------------------------	-------------------	------------------------------------------	----------------

5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1881</b>	9. AGE (last birthday) <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------	---------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------	-------------------------------------	-------------------------------------------	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Clark County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
----------------------------------------------------------------------------------------------------------------------	-----------------------------------	------------------------------------------------------------------------	------------------------------------------------

13a. FATHER'S NAME <b>James Böley</b>	13b. MOTHER'S MAIDEN NAME <b>Huldah Douglas</b>	14. NAME OF HUSBAND OR WIFE <b>Etta Claire Böley</b>
------------------------------------------	----------------------------------------------------	---------------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>489-14-7581</b>	17. INFORMANT <b>Mrs. Ruth Wickham Lewistown, Ill</b>	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) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 Min</b>
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)	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
-----------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 a.m. p.m.	Month, Day, Year
---------------------------------------	------------------

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 **1:30 A** to **Dec 20** and last saw him **alive on Dec 19**  
Death occurred at **1:30 A** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>L. E. Lowe</b> (Degree or title)	22b. ADDRESS <b>Memphis Mo</b>	22c. DATE SIGNED <b>12-21-59</b>
-------------------------------------------------------	-----------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/23/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Combs Cemetery</b>	23d. LOCATION (City, town, or county) <b>Luray, Missouri</b>	(State)
------------------------------------------------------------	------------------------------	-------------------------------------------------------------	-----------------------------------------------------------------	---------

24. FUNERAL DIRECTOR <b>Lester B. Whit</b> ADDRESS <b>Memphis Mo</b>	25. DATE RECD. BY LOCAL REG. <b>12/22-59</b>	26. REGISTRAR'S SIGNATURE <b>JR Douglas</b>
----------------------------------------------------------------------------	-------------------------------------------------	------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 13 1961

**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 \_\_\_\_\_  
*Yves Luts*

Licensed Embalmer No. 425

P. O. Address \_\_\_\_\_  
*MM*

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.