

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS JAN - 5 1960

STATE FILE NUMBER

Registration District No. 133 Primary Registration District No. _____ Registrar's No. 173

UNDECEASED

1. PLACE OF DEATH a. COUNTY Harrison			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Harrison			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Gainsville		Length of stay in 1b 18 years	c. CITY OR TOWN Gainsville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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)		
3. NAME OF DECEASED (Type or print) First Susan Middle Elizabeth Last Boyd			4. DATE OF DEATH Month December Day 26 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-7-1864	9. AGE (last birthday) 95	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Ohio	12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Samuel Elliott			13b. MOTHER'S MAIDEN NAME Rebecca Osborn		14. NAME OF HUSBAND OR WIFE Santford C. Boyd. (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None	17. INFORMANT Daisy Axson Address Gainsville, Mo.		

DOCUMENT

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 Cardiac Decompression			INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chronic Arteriosclerosis and stroke from fall in August, 1958, which resulted in left hemiparesis since age		Slight
DUE TO (c) Age			She was 95

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) She had a fall also on Dec. 19, 1959, and went into a coma, respiration on the 20th of December		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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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 _____ Month _____ Day _____ Year _____ see above		These two falls were slightly centrifugally		
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 **Feb. 24, 1956** to **Dec 26, 1959** and last saw her alive on **7 pm on Dec 26, 1959**
Death occurred at **9:35 P.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS Gainsville, Mo.		22c. DATE SIGNED 12-28-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-29-59	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	23d. LOCATION (City, town, or county) (State) RD Gainsville, Mo.		

24. GENERAL DIRECTOR <i>[Signature]</i>		ADDRESS Gainsville, Mo.	25. DATE RECD. BY LOCAL REG. 12-29-1959	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
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MEDICAL CERTIFICATION

BY AFFIDAVIT OF

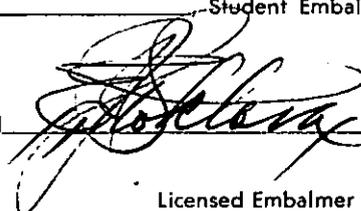
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by Eddie J. Stoklasa Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____
Licensed Embalmer No. 3602

P. O. Address Cainsville, 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.