

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-009706

FILED VS FEB 17 1960

STATE FILE NUMBER

Registration District No. 378 Primary Registration District No. 4552 Registrar's No. 8

ENDED

1. PLACE OF DEATH a. COUNTY <u>WRIGHT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>WRIGHT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MTN. GROVE</u>		Length of stay in 1b <u>2 mo.</u>	c. CITY OR TOWN <u>HARTVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MTN. GROVE REST HOME</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>xxx CITY</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>EMELY</u> Middle <u>BOYER</u> Last <u>BOYER</u>			4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1960</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>11/17/69</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>27</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>10 years of working life as a</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>IONA</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>BEN ZIEGLER</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED</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>UNKNOWN</u>	17. INFORMANT <u>MTN. GROVE REST HOME</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>CEREBRAL EMBOLISM</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>FRACTURE OF HIP.</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u></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
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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.) <u></u>
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u>	STATE <u></u>
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21. I attended the deceased from <u>6-12-1950</u> to <u>2-3-1960</u> and last saw him/her alive on <u>2-7-1960</u> Death occurred at <u>11 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>W. A. Craig D.O.</u>	22b. ADDRESS <u>MOUNTAIN GROVE, MO</u>	22c. DATE SIGNED <u>2-10-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/9/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bado Cemetery.</u>	23d. LOCATION (City, town, or county) <u>Texas Co. MISSOURI</u>
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24. FUNERAL DIRECTOR <u>John Simpson Hartsville, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2-10-1960</u>	26. REGISTRAR'S SIGNATURE <u>Bessie L Silverman</u>
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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 Warren Simpson
Licensed Embalmer No. 5071
P. O. Address Marquette

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