

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS MAY 17 1960

-60-019932

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. Registrar's No. 78

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>La clede.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Dove, Missouri</u>	Length of stay in 1b <u>5 years.</u>	c. CITY OR TOWN <u>Crocker, Missouri</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>Cedar Grove N.Home.</u>		d. STREET ADDRESS (If outside, give location) <u>None.</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>C.</u> Last <u>Boren.</u>	4. DATE OF DEATH Month <u>May</u> Day <u>3,</u> Year <u>1960</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>10/5/1879</u>	9. AGE (last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </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 -----	11. BIRTHPLACE (City and state or country) <u>Camden County, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
-------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------	-------------------------------------------------------------------------------	-----------------------------------------------------

13a. FATHER'S NAME <u>Amsterdam Wall.</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Shelton.</u>	14. NAME OF HUSBAND OR WIFE <u>Charley Boren</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 Address <u>Henry Boren Crocker, Missouri</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>Fracture Rt Hip</u>	INTERVAL BETWEEN ONSET AND DEATH <u>one week</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)	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
-----------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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>Fell on floor</u>
----------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour <u>5</u> p.m. Month, Day, Year <u>5-1-60</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.) <u>Nursing Home</u>	20f. CITY, TOWN, OR LOCATION <u>Dove</u>	COUNTY <u>Laclede</u> STATE <u>Mo.</u>
--------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------	------------------------------------------------------

21. I attended the deceased from 5/1/60 to 5/3/60 and last saw her alive on 5/1/60
 Death occurred at 3:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Degree or title) <u>Dr. R. E. Fisher M.D.</u>	21b. ADDRESS <u>Lebanon, Missouri</u>	21c. DATE SIGNED <u>5/6/60</u>
-------------------------------------------------------------------------	-------------------------------------------------	------------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/4/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Iberia, Missouri</u>
-------------------------------------------------------------------	-----------------------------------	----------------------------------------------------------------------------	---------------------------------------------------------------------------------

24. FUNERAL DIRECTOR <u>Herbes Funeral Home Crocker, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>5-7-1960</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. May</u>
-----------------------------------------------------------------------	--------------------------------------------------------	---------------------------------------------------------

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clarence E. Moss

Licensed Embalmer No. 4896

P. O. Address Waynesville, M

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.