

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS MAY 31 1960**

**-60-020181**

Registration District No. 227 Primary Registration District No. 5804 Registrar's No. 17

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>MONROE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MONROE</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JACKSON TWP.</u>		Length of stay in 1b <u>2 YRS.</u>		c. CITY OR TOWN <u>PARIS</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>PLEASANT VIEW BEST HOME</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1/4 MI. E. OF PARIS, MO</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>STELLA (UNKNOWN) BOARD</u>				4. DATE OF DEATH Month Day Year <u>MAY 20 1960</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12/31/1878</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</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>AT HOME</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>SNOWDEN BOARD</u>			13b. MOTHER'S MAIDEN NAME <u>AMANDA SUTER</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</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>J. WM. SUTER, KAHOKA, 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>Cerebral Embolism</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 Days</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arterio-sclerosis</u>							<u>21 1/2</u>		
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 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 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 <u>May 10</u> to <u>May 20</u> and last saw her alive on <u>May 20</u> . Death occurred at <u>4:15 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>J. A. Barnett M.D.</u>				22b. ADDRESS <u>PARIS, MO.</u>			22c. DATE SIGNED <u>5/21/1960</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>5/22/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>PARIS, M.D.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>E. H. AGNEW PARIS, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>May 22, 1960</u>		26. REGISTRAR'S SIGNATURE <u>J. A. Barnett M.D.</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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed E. H. Ognew

Licensed Embalmer No. 4000

P. O. Address Paris, Mo

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