

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-029413**

**FILED VS JUL 19 1960**

360

Registration District No. \_\_\_\_\_ Primary Registration District No. 6225 Registrar's No. 143

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		Length of stay in 1b <u>5 yrs.</u>		c. CITY OR TOWN <u>Flemington</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>St. Hosp. # 3</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		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>Earl</u> Middle _____ Last <u>Boyle</u>				4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1960</u>					
5. SEX <u>Male</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>11-16-93</u>	9. AGE (last birthday) <u>66</u>	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) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Fostoria, Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>George Boyle</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Bain</u>			14. NAME OF HUSBAND OR WIFE <u>Unknown (Deceased)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War I</u>			16. SOCIAL SECURITY NO. <u>497-26-9426</u>		17. INFORMANT <u>Records of St. Hosp. # 3, Nevada, Missouri</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Coronary Vessel Disease</u>							<u>Years</u>		
DUE TO (b) <u>Status Epilepticus</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) <u>Chronic Brain Syndrome Associated with Circulatory Disturbance with Psychotic Reaction.</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		
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 <del>XXXXXX</del> <u>2-10-55</u> to <u>7-8-60</u> and last saw <sup>XX</sup> him alive on <u>7-8-60</u> Death occurred at <u>5:25 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Paul L Barone MD</u>				22b. ADDRESS <u>St. Hosp. # 3, Nevada, Mo.</u>				22c. DATE SIGNED <u>July 8/60</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		23b. DATE <u>7-8-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dosy Bond Cemetery, Walnutland, Mo.</u>			23d. LOCATION (City, town, or county) <u>Walnutland, Mo.</u>			
24. FUNERARY DIRECTOR <u>Gilbert Anthony - Walnutland, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>7-16-1960</u>		26. REGISTRAR'S SIGNATURE <u>Anna E. Perry</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 25 1960

**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 *Chas. Albert F. Hathaway*

Licensed Embalmer No. 4267

P. O. Address *Wheatland*

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.