

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035633

STATE FILE NUMBER

FILED VS 6 OCT 7 1960 Registration District 270 Primary Registration District No. 3050 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY Pemiscot		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pemiscot	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Caruthersville		Length of stay in 1b 40yrs	c. CITY OR TOWN Caruthersville
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION none		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 11 Eastwood Ave
3. NAME OF DECEASED (Type or print) First Middle Last Ora Boyd		4. DATE OF DEATH Month Day Year Sept. 18-1960	
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Nightwatchman	9. AGE (last birthday) 74
13a. FATHER'S NAME Wm. S. Boyd		13b. MOTHER'S MAIDEN NAME Unknown	12. CITIZEN OF WHAT COUNTRY U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		14. NAME OF HUSBAND OR WIFE Alice Boyd	
17. INFORMANT Alice Boyd, Caruthersville, Mo		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia			INTERVAL BETWEEN ONSET AND DEATH 3 yrs
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 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 Month, Day, Year a.m. p.m.			
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 1955 to 9-18-60 and last saw her/him alive on 9-17-60 Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. W. Mitchell M.D.		22b. ADDRESS Caruthersville, Mo.	22c. DATE SIGNED 9-25-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 19, 1960	23c. NAME OF CEMETERY OR CREMATORY Little Prairie	23d. LOCATION (City, town, or county) (State) Caruthersville, Mo
24. FUNERAL DIRECTOR Noel G. Dean Caruthersville, Mo		25. DATE RECD. BY LOCAL REG. 9-28-1960	26. REGISTRAR'S SIGNATURE Jack W. Tipton

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 *Paul C. Swan*

Licensed Embalmer No. 394
P. O. Address Canville

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.