

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-037734

300  
1-57  
80

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|                                                                                                                                                                                                                                                                                                                           |                                  |                                                                                                                                                               |                                                                                              |                                                                      |                                                   |                                                                                                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|--|
| FILED VS NOV 4 1960                                                                                                                                                                                                                                                                                                       |                                  | Registration District No. 58                                                                                                                                  |                                                                                              | Primary Registration District No. 5214                               |                                                   | STATE FILE NUMBER                                                                                                 |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>CARTER</b>                                                                                                                                                                                                                                                                              |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>CARTER</b>                     |                                                                                              |                                                                      |                                                   |                                                                                                                   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR <b>JOHNSON TWP</b><br>TOWN                                                                                                                                                                                                                                |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                          |                                                                                              | c. CITY<br>OR <b>ELLSINORE</b><br>TOWN                               |                                                   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                              |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR <b>Rt 2 ELLSINORE</b><br>INSTITUTION                                                                                                                                                                                                                   |                                  | Length of stay in lb<br><b>40 YRS</b>                                                                                                                         |                                                                                              | d. STREET<br>ADDRESS <b>Rt 2</b>                                     |                                                   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                             |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>PHOEBE</b> Middle <b>ELLA</b> Last <b>BOYER</b>                                                                                                                                                                                                                        |                                  |                                                                                                                                                               |                                                                                              | 4. DATE OF DEATH<br>Month <b>Aug</b> Day <b>3</b> Year <b>1960</b>   |                                                   |                                                                                                                   |  |
| 5. SEX<br><b>1 FEMALE</b>                                                                                                                                                                                                                                                                                                 | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>1 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MARCH 30 1884</b>                                                     | 9. AGE (In years last birthday)<br><b>76</b>                         | 10. UNDER 1 YEAR<br>Months <b>4</b> Days <b>3</b> | IF UNDER 24 HRS<br>Hours <b>3</b> Min.                                                                            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                                                                                                                                                                                           |                                  | 10b. KIND OF BUSINESS OR INDUSTRY                                                                                                                             |                                                                                              | 11. BIRTHPLACE (City and state or country)<br><b>0 Carter Co. Mo</b> |                                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                     |  |
| 13a. FATHER'S NAME<br><b>George GRESHAM</b>                                                                                                                                                                                                                                                                               |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>JULIA ANN LEACH</b>                                                                                                           |                                                                                              | 14. NAME OF HUSBAND OR WIFE<br><b>Samuel Boyer</b>                   |                                                   |                                                                                                                   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                                                                                                  |                                  | 16. SOCIAL SECURITY NO.<br><b>✓</b>                                                                                                                           |                                                                                              | 17. INFORMANT<br>Address <b>Samuel Boyer Rt 2, ELLSINORE Mo</b>      |                                                   |                                                                                                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Carter's disease</b><br>DUE TO (c) <b>331X</b> |                                  |                                                                                                                                                               |                                                                                              |                                                                      |                                                   | INTERVAL BETWEEN ONSET AND DEATH                                                                                  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)                                                                                                                                                                                         |                                  |                                                                                                                                                               |                                                                                              |                                                                      |                                                   | 19. WAS AUTOPSY PERFORMED?<br><b>2 YES</b> <input type="checkbox"/> <b>NO</b> <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<br>Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> Month, Day, Year                                                                                                                                                                                         |                                  |                                                                                                                                                               |                                                                                              |                                                                      |                                                   |                                                                                                                   |  |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <b>July 26 1960</b> to <b>Aug 3 1960</b> and last saw her alive on <b>Aug 2 1960</b><br>Death occurred at <b>6:15 PM</b> on the date stated above; and to the best of my knowledge, from the causes stated.                                                                              |                                  |                                                                                                                                                               |                                                                                              |                                                                      |                                                   |                                                                                                                   |  |
| 22a. SIGNATURE<br><b>Dr. H. H. H. H. H.</b> (Degree or title)                                                                                                                                                                                                                                                             |                                  |                                                                                                                                                               |                                                                                              | 22b. ADDRESS<br><b>Prof. H. H. H. H. H.</b>                          |                                                   | 22c. DATE SIGNED<br><b>70 31 1960</b>                                                                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>                                                                                                                                                                                                                                                                |                                  | 23b. DATE<br><b>8-5-60</b>                                                                                                                                    |                                                                                              | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GRESHAM Cemetery</b>        |                                                   | 23d. LOCATION (City, town, or county) (State)<br><b>Carter Co. Mo</b>                                             |  |
| 24. FUNERAL DIRECTOR<br><b>McSpadden</b>                                                                                                                                                                                                                                                                                  |                                  | ADDRESS<br><b>Van Buren, Mo</b>                                                                                                                               |                                                                                              | 25. DATE RECD. BY LOCAL REG.<br><b>Nov. 1-1960</b>                   |                                                   | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Ota Flenson</b>                                                              |  |

MEDICAL CERTIFICATION

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 Donald B. Dean, Student Embalmer No. 606 working under my personal supervision.

Student Donald B. Dean  
Signature of Student Embalmer

Signed Allen C. McFadden

Licensed Embalmer No. 4543

P. O. Address Van Buren,

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.