

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000574

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

3-8

Primary Registration District No.

3214

Registrar's No.

1

STATE FILE NUMBER

WRITE  
STUB

AMENDED

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|                                                                                                                                                                                                                                                                                                                         |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                       |                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>CARTER</u>                                                                                                                                                                                                                                                                            |  |                                                                                                           |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>CARTER</u>                   |  |                                                                                       |                                                                                                                                                                      |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>ELLSINORE</u>                                                                                                                                                                                                                                   |  | Length of stay in 1b<br><u>36 year</u>                                                                    |  | c. CITY OR TOWN <u>ELLSINORE</u>                                                                                                                            |  | 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 INSTITUTION <u>Residence</u>                                                                                                                                                                                                                         |  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                      |  | d. STREET ADDRESS (If outside, give location)<br><u>Rt. 1</u>                                                                                               |  | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                                                                                                                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <u>EVA</u> Middle <u>LENA</u> Last <u>Boxx</u>                                                                                                                                                                                                                             |  |                                                                                                           |  | 4. DATE OF DEATH<br>Month <u>JAN</u> Day <u>20</u> Year <u>1961</u>                                                                                         |  |                                                                                       |                                                                                                                                                                      |
| 5. SEX<br><u>FEMALE</u>                                                                                                                                                                                                                                                                                                 |  | 6. COLOR OR RACE<br><u>WHITE</u>                                                                          |  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>3-20-91</u>                                                    |                                                                                                                                                                      |
| 9. AGE (last birthday)<br><u>79</u>                                                                                                                                                                                                                                                                                     |  | IF UNDER 1 YEAR<br>Months <u>10</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>                            |  | IF UNDER 24 HR<br>Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>                                                                                |  |                                                                                       |                                                                                                                                                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSE WIFE</u>                                                                                                                                                                                                        |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>FARM</u>                                                          |  | 11. BIRTHPLACE (City and state or country)<br><u>BUTLER CO. MO. U.S.A.</u>                                                                                  |  | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>                                          |                                                                                                                                                                      |
| 13a. FATHER'S NAME<br><u>Fouts</u>                                                                                                                                                                                                                                                                                      |  | 13b. MOTHER'S MAIDEN NAME<br><u>MARTHA</u>                                                                |  | 14. NAME OF HUSBAND OR WIFE<br><u>JAMES W. Boxx - Deed</u>                                                                                                  |  |                                                                                       |                                                                                                                                                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)                                                                                                                                                                                                    |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>                                                                    |  | 17. INFORMANT<br><u>ASA Boxx Rt, ELLSINORE MO</u>                                                                                                           |  |                                                                                       |                                                                                                                                                                      |
| 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) <u>Cerebral hemorrhage</u><br>DUE TO (b) <u>arteriosclerosis</u><br>DUE TO (c) <u>AGE</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                       | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 week</u>                                                                                                                    |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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>1-1-1961</u> to <u>1-20-1961</u> and last saw her/him alive on <u>1-17-1961</u><br>Death occurred at <u>12:25 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.                                                                             |  |                                                                                                           |  |                                                                                                                                                             |  |                                                                                       |                                                                                                                                                                      |
| 22a. SIGNATURE (Degree or title)<br><u>Wm Henson M.D.</u>                                                                                                                                                                                                                                                               |  |                                                                                                           |  | 22b. ADDRESS<br><u>P.O. Box 120</u>                                                                                                                         |  | 22c. DATE SIGNED<br><u>1-23-61</u>                                                    |                                                                                                                                                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>                                                                                                                                                                                                                                                              |  | 23b. DATE<br><u>1-22-1961</u>                                                                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>HENSON CEMETERY</u>                                                                                                |  | 23d. LOCATION (City, town, or county) (State)<br><u>CARTER Co. MO.</u>                |                                                                                                                                                                      |
| 24. FUNERAL DIRECTOR<br><u>McSpadden</u>                                                                                                                                                                                                                                                                                |  | ADDRESS<br><u>Van Buren, Mo</u>                                                                           |  | 25. DATE RECD. BY LOCAL REG.<br><u>Jan. 25-61</u>                                                                                                           |  | 26. REGISTRAR'S SIGNATURE<br><u>Mrs Octa Henson</u>                                   |                                                                                                                                                                      |

(Licensed Embalmer's Statement on Reverse Side)

**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 Donald Sloan

Licensed Embalmer No. 5127

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.