

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028210

Registration District No. 379 Primary Registration District No. 4553 Registrar's No. 27

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH a. COUNTY <u>WRIGHT</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MANSfield</u> Length of stay in 1b <u>3hrs</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MANSfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>CALIFORNIA</u> b. COUNTY <u>LOS ANGELES</u> c. CITY OR TOWN <u>Glendale</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>419 E. Hubbard</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Winnie Lou Floe Boykin</u>			4. DATE OF DEATH Month Day Year <u>July 27 1961</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>JAN. 18, 1948</u>
9. AGE (last birthday) <u>19</u>		IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PACKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BAKERY</u>	11. BIRTHPLACE (City, and state or country) <u>MACOMB MO.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Freddie Roosevelt Boykin</u>	13b. MOTHER'S MAIDEN NAME <u>MARtha Elizabeth Hicks</u>
14. NAME OF HUSBAND OR WIFE		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.		17. INFORMANT <u>Leo Boykin</u> Address <u>Sylmar California</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>Fractured skull, severe skull fracture</u> DUE TO (b) <u>Pressure</u> DUE TO (c) <u>Fracture left humerus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>7-26-61</u> <u>7-26-61</u> <u>6-26-61</u> <u>6-26-61</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. <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 checked="" 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.) <u>Automobile Collision 7-26-61</u>	
20c. TIME OF INJURY <u>11:15 p.m.</u>	Month, Day, Year <u>July 26 1961</u>	<u>2 1/2 Miles West Mansfield MO Highway 60</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>2:40 A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Carl Crow</u> (Doctor or title)		22b. ADDRESS <u>Mountain Grove MO</u>	22c. DATE SIGNED <u>7-31-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>July 31, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VAN ZANT</u>	23d. LOCATION (City, town, or county) (State) <u>Douglas County Mo.</u>
24. FUNERAL DIRECTOR <u>Max &amp; Miller</u> ADDRESS <u>Mansfield Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Aug 14 61</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 8 AUG

**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 Max J Miller

Licensed Embalmer No. 4720

P. O. Address Manfield Mo

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.