

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041588
STATE FILE NUMBER

AMENDED

Registered District No. 383 Primary Registration District No. 5607 Registrar's No. 112
FILED NOV 29 1961

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Freistatt</u>		c. CITY OR TOWN <u>Ash Grove</u>	
Length of stay in 1b <u>3 weeks</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>Crestview Nursing Home</u>		d. STREET ADDRESS (If outside, give location) <u>North Part Town</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Kirk</u> Last <u>Boyd</u>			4. DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1961</u>		
---	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-1872</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR. Hours <u> </u> Min. <u> </u>
--------------------	-------------------------------	--	-----------------------------------	----------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Dade County Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	--	---	---

13a. FATHER'S NAME <u>Joseph Boyd</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Jones</u>	14. NAME OF HUSBAND OR WIFE <u>Fannie Boyd</u>
---------------------------------------	---	--

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. <u>None</u>	17. INFORMANT Address <u>Mrs R. K. Boyd Ash Grove Mo.</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>Cerebratory Failure</u>		<u>1 hour</u>
DUE TO (b) <u>Coronary Thrombosis</u>		<u>12 hour</u>
DUE TO (c) <u>arteriosclerosis & Ischemia of heart</u>		<u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pneumonia</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N: <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 <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </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 <u>Nov 2 1961</u> to <u>Nov 18 1961</u> and last saw ^{her} him alive on <u>Nov 18 1961</u>	
Death occurred at <u>4:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <u>David E. George D.O.</u>	22b. ADDRESS <u>Mt Vernon Mo.</u>	22c. DATE SIGNED <u>11/20/61</u>
--	-----------------------------------	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Nov. 20 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ash Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Ash Grove Mo.</u>
---	-------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS <u>J.W. Buck Ash Grove Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-24-61</u>	26. REGISTRAR'S SIGNATURE <u>Roy Wynne</u>
---	--	--

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard E. Watts

Licensed Embalmer No. 4657

P. O. Address Oak Grove

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.