

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-044203

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1230

STATE FILE NUMBER

AMENDED

FILED DEC 18 1961

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> Length of stay in 1b <u>75 years</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Handley Hospital</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>Mo.</u> b. COUNTY <u>Greene</u> c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Route #9</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
|---|--|---|--|

| | | | | | |
|--|---|--|--|---|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Rebecca Malinda Boyer</u> | | | 4. DATE OF DEATH Month Day Year <u>12 9 1961</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/25/1863</u> | 9. AGE (last birthday) <u>98</u> | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Effingham Co., Ill.</u> | | 11. BIRTHPLACE (City and state or country) <u>USA</u> | |
| 13a. FATHER'S NAME <u>David Richards</u> | | 13b. MOTHER'S MAIDEN NAME <u>Malinda Groves</u> | | 14. NAME OF HUSBAND OR WIFE <u>George W. Boyer</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>Roy D. Boyer Rt. #9, Springfield</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) Arteriosclerotic Heart Disease

DUE TO (b) Fract. of Knee, Old Hip Injury

DUE TO (c) _____

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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.
 Yes No 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>Fell at Home</u> | | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>12-6-61</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.) <u>Home</u> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Springfield Greene Mo.</u> | | |
| 21. I attended the deceased from <u>12/6/61</u> to <u>12/9/61</u> and last saw her alive on <u>12/9/61</u> 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) <u>Leyman D. Brown M.D.</u> | | 22b. ADDRESS <u>311 1/2 College</u> | | 22c. DATE SIGNED <u>12/12/61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-13-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Hazelwood</u> | 23d. LOCATION (City, town, or county) (State) <u>Springfield, Mo</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Ralph Thieme 1200 Boonville Springfield, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>12-12-61</u> | 26. REGISTRAR'S SIGNATURE <u>Effie S. Meeton</u> | |

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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

Harold Futrell

Licensed Embalmer No. 507

P. O. Address Spfld, Va

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.