

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-009781

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 13 Primary Registration District No. 3003 Registrar's No. 41

FILED MAR 29 1962

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Barry		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Lawrence	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Monett		c. CITY OR TOWN Mt. Vernon	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Scroggins Nursing Home		d. STREET ADDRESS (If outside, give location) 923 So. Linn	
3. NAME OF DECEASED (Type or print) Ollie Auletta Boster		4. DATE OF DEATH March 19 1962	
5. SEX Female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/10/1876
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11a. BIRTHPLACE (City and state or country) Lebanon, Mo.		11b. CITIZEN OF WHAT COUNTRY USA	
12a. FATHER'S NAME James A. Boster		12b. MOTHER'S MAIDEN NAME Rebecca Ann Shipley	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
14a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14b. SOCIAL SECURITY NO.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ethel Boster		18. NAME OF HUSBAND OR WIFE none	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Ethel Boster	
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>Myocardial degeneration</u> DUE TO (b) <u>Coronary failure</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 W 3</u> <u>2 W 6</u> <u>2 Y 3</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 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 a.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>3-8-62</u> to <u>3-19-62</u> and last saw her/him alive on <u>3-18-62</u> . Death occurred at <u>10:00 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Name or title) <u>Frank B. Boster MD</u>		22b. ADDRESS <u>Monett Mo.</u>	
22c. DATE SIGNED <u>3-21-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 3/22/1962	
23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION (City, town, or county) (State) Mt. Vernon, Mo.	
24. FUNERAL DIRECTOR Max L. Fossett		25. DATE RECD. BY LOCAL REG. 3-22-62	
ADDRESS Mt. Vernon, Mo.		26. REGISTRAR'S SIGNATURE <u>Mrs. P.N. Cook</u>	

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 L. Fossell

Licensed Embalmer No. 4252

P. O. Address W. W. Keenan, 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.