

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-018051

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 550

STATE FILE NUMBER

FILED MAY 21 1962

1. PLACE OF DEATH
 a. COUNTY Buchanan
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph Length of stay in 1b 60yrs
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 317 W Valley Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Mo b. COUNTY Buchanan
 c. CITY OR TOWN St. Joseph, Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 317 W Valley Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last (Type or print) Clyde John Boyd 4. DATE OF DEATH Month Day Year May 11, 1962

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH June 6, 1899 9. AGE (last birthday) 62 IF UNDER 1 YEAR IF UNDER 24 HR
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) re. Plasterer 10b. KIND OF BUSINESS OR INDUSTRY Self 11. BIRTHPLACE (City and state or country) Sparks Kansas 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME John Calvin Boyd 13b. MOTHER'S MAIDEN NAME Elfa Carter 14. NAME OF HUSBAND OR WIFE Marie Boyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 16. SOCIAL SECURITY NO. unk 17. INFORMANT Address Marie Boyd, St. Joseph, Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Chronic pulmonary fibrosis and emphysema INTERVAL BETWEEN ONSET AND DEATH Unknown
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic bronchitis Unknown
 DUE TO (c) _____
 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 NO 20a. ACCIDENT SUICIDE HOMICIDE 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. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 3/10/61 to 5/11/62 and last saw him live on 5/9/62
 Death occurred at 10:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (In free or title) Charles H. Bascom 22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo. 22c. DATE SIGNED 5/14/62

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 5/13/62 23c. NAME OF CEMETERY OR CREMATORY Odd fellows Public Cemetery 23d. LOCATION (City, town, or county) (State) St. Joseph, Mo

24. FUNERAL DIRECTOR ADDRESS St. Joseph, Mo 25. DATE RECD. BY LOCAL REG. May 17, 1962 26. REGISTRAR'S SIGNATURE Mr. Clark Goodell

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

C. H. Bascom, M.D. BY AFFIDAVIT OF CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

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,

by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St. Joseph, 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.