

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-000068

STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 26

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 28 1963

1. PLACE OF DEATH a. COUNTY <u>AUDRAIN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MEXICO</u>		Length of stay in 1b <u>3 DAYS</u>	c. CITY OR TOWN <u>PARIS</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>AUDRAIN CO. HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>MILL ST.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>EULA</u> Middle <u>MAE</u> Last <u>BOLDEN</u>			4. DATE OF DEATH Month <u>JAN</u> Day <u>20</u> Year <u>1963</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>NEGRO</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>7/15/1916</u>	9. AGE (last birthday) <u>46</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>5</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>HOUSE MAID</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE CLEANING</u>		11. BIRTHPLACE (City and state or country) <u>OKLAHOMA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>V. ALLEN</u>		13b. MOTHER'S MAIDEN NAME <u>ALICE M. REED</u>		14. NAME OF HUSBAND OR WIFE <u>ROBERT D. BOLDEN</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.		17. INFORMANT Address <u>MILL ST</u> <u>ROBERT D. BOLDEN PARIS, MO.</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) Carcinomatosis Secondary to Ovarian Carcinoma.
(Admitted to Ellis Fischel Hospital 12-12-62)
DUE TO (b) discharge 1-16-63

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

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
None

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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>X</u>
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20c. TIME OF INJURY Hour <u>X</u> a.m. <u>X</u> p.m.	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>X</u>	20f. CITY, TOWN, OR LOCATION <u>X</u>	COUNTY	STATE
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21. I attended the deceased from 10-4-62 to 1-20-63 and last saw her alive on 1-19-63
Death occurred at 1-20-63 6:00 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Harry F O'Brien M.D.</u>	22b. ADDRESS <u>1116 Monroest Mexico Mo.</u>	22c. DATE SIGNED <u>1/20/63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1/24/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE</u>	23d. LOCATION (City, town, or county) <u>PARIS, MO.</u>
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24. FUNERAL DIRECTOR <u>E. H. AGNEW</u>	ADDRESS <u>PARIS, MO.</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 20-1963</u>	26. REGISTRAR'S SIGNATURE <u>Blanche Neely</u>
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Rev. 4/59
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

MARGY F O'Brien MD

Permit obtained
1-20-63
1311.

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 E. M. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, 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.