

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 3 1959 **73**

**59-028463**

Registration District No. **73** Primary Registration District No. **3014** Registrar's No. **104**

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Clay</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Liberty</b> Length of stay in 1b <b>1 yr 3</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>32 S. Main St.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clay</b> c. CITY OR TOWN <b>Liberty</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>322 N. Main St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Ollie</b> Middle <b>Boswell</b> Last <b>Boswell</b> <b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>Negro</b> <b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>12-3-1887</b> <b>9. AGE</b> (last birthday) <b>71</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Domestic</b> <b>11. BIRTHPLACE</b> (City and state or country) <b>Kearney, Missouri</b> <b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>27</b> Year <b>1959</b> <b>IF UNDER 1 YEAR</b> Months <b>Days</b> <b>Hours</b> <b>Min.</b> <b>IF UNDER 24 HR</b>			
<b>13a. FATHER'S NAME</b> <b>Milton Jackson</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Eveline Mosby</b> <b>16. SOCIAL SECURITY NO.</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Jesse Boswell</b> <b>17. INFORMANT</b> <b>Dave Jackson</b> Address <b>Liberty, Missouri</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Coronary occlusion, June 23, 1959</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension and arteriosclerosis</b> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ <b>20f. CITY, TOWN, OR LOCATION</b> _____ <b>COUNTY</b> _____ <b>STATE</b> _____					
<b>21. I attended the deceased from</b> <b>March 10, 1959</b> <b>to</b> <b>August 27, 1959</b> <b>and last saw her</b> <b>alive on</b> <b>August 27, 1959</b> <b>Death occurred at</b> <b>10:30 A</b> <b>m</b> <b>on the date stated above, and to the best of my knowledge, from the causes stated.</b>							
<b>22a. SIGNATURE</b> <i>Samuel Shilloughly</i> (Deceased or title)		<b>22b. ADDRESS</b> <b>32 South Main Street, Liberty, Mo.</b>		<b>22c. DATE SIGNED</b> <b>8/28/59</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>AUG 29, 1959</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fairview Cemetery</b>			
<b>23d. LOCATION</b> (City, town, or county) <b>Liberty, Missouri</b> (State)		<b>24. FUNERAL DIRECTOR</b> <b>Church-Archer Co. Liberty, Missouri</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>8-29-59</b> <b>26. REGISTRAR'S SIGNATURE</b> <i>Mabel Graham</i>			

(Licensed Embalmer's Statement on Reverse Side)

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John Embury*

Licensed Embalmer No. 4448

P. O. Address

*Liberty*

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.