

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 25 1946  
82

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36480

State File No. \_\_\_\_\_  
Registrar's No. 107

Registration District No. 82 Primary Registration District No. 3017

1. PLACE OF DEATH:  
(a) County COOPEY  
(b) City or town BOONVILLE  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: RYUENS WAYS 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 WEEKS  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County COOPEY 27  
(c) City or town (PUTAW) SARGINE 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MINNIE E. ENLOE  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct day 21  
year 1946 hour 2 pm minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Dec Sept 26  
1946 to Oct 21 1946  
that I last saw him alive on Oct 21 1946  
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife L. M. Enloe 6. (c) Age of husband or wife if alive 53 years  
7. Birth date of deceased 10 16 1899  
(Month) (Day) (Year)

Immediate cause of death  
Due to Intestinal obstruction  
fungus  
Carcinoma of  
peritoneal cavity  
Due to Ca. of ovaries  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
47 0 5 hr. \_\_\_\_\_ min.

9. Birthplace MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name JACOB BOYTS  
13. Birthplace PENNSYLVANIA  
(City, town, or county) (State or foreign country)  
14. Maiden name MARY TAMPSON  
15. Birthplace MISSOURI  
(City, town, or county) (State or foreign country)

Major findings: Ca. of ovaries  
Of operations: Meta. Ex. ca. of intestines  
Of autopsy: none 25 July 1946  
Underline the cause to which death should be charged statistically.

16. (a) Informant L. M. Enloe  
(b) Address Prairie Home mo  
17. (a) REMOVAL (b) Date thereof 10-21-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation ZION C.E.M.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director C. Albert Hornbeck  
(b) Address Prairie Home mo  
19. (a) Oct 22, 1946 (b) Clay Morris  
(Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature of Physician (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 10.21.46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

7  
1  
2  
35302

RECEIVED

Civilian Health License No.

District of Columbia

Date Filed 11-23-46

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home 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 this body is not embalmed, fact should be so stated above.**