

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-033011

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 70

**FILED AUG 26 1963**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 0710

2 0691

3

4 0

5 2

6

7 0

8 2

9 332X

10

11

12 860

13 20

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>MORGAN</b>		2. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>MONTEAU</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>VERSAILLES</b>		Length of stay in 1b <b>36 DAYS</b>	c. CITY OR TOWN <b>CALIFORNIA</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>KIDWELL REST HOME</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>HILL HOTEL</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>CALVIN</b> Last <b>BOYLES</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>22</b> , Year <b>1963</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/26/1891</b>
9. AGE (last birthday) <b>72</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ORNAMENTAL IRON WORK</b>	11. BIRTHPLACE (City and state or country) <b>Howard County, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>WILLIAM BOYLES</b>	
13b. MOTHER'S MAIDEN NAME <b>BELLE DOBSON</b>		14. NAME OF HUSBAND OR WIFE <b>ETHEL MUSICK (DEC.)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>492-03-2499-A</b>	17. INFORMANT <b>Mrs. Paul Bealer, Tipton, Missouri</b>
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>1 month</b>	
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. _____ p.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 <b>Versailles, Mo.</b> COUNTY _____ STATE _____	
21. I attended the deceased from <b>July 1963</b> to <b>Aug 22 1963</b> and last saw him alive on <b>8-22-63</b> Death occurred at <b>7:00</b> m on the date stated above, and to the best of my knowledge, from the causes stated:			
22a. SIGNATURE <b>Jack Gunnard</b> (Degree or title)		22b. ADDRESS <b>Versailles, Mo.</b>	22c. DATE SIGNED <b>8-23-63</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>Aug 25, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CLARKSBURG MASONIC</b>	23d. LOCATION (City, town, or county) <b>CLARKSBURG, MISSOURI</b>
24. FUNERAL DIRECTOR <b>HUGH E. WILLIAMS, CALIFORNIA, MISSOURI</b> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <b>8-24-63</b>	26. REGISTRAR'S SIGNATURE <b>J. L. Washburn</b>

**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

*Russell C. Maag*

Licensed Embalmer No. 4804

P. O. Address California, 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.