

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important!

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32593
Do not use this space.

1. PLACE OF DEATH

(a) County Monticau Registration District No. 541
(b) Township Hubbel Primary Registration District No. 4335
(c) City California (d) Street No. _____ Registered No. 50
(e) Length of residence in city or town where death occurred, yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Ethel Ollie Boyles
(a) Residence, No. California St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Charles Boyles

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 3, 1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
39 11 24

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Parts factory
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monticau Co Mo

13. NAME Fred Musick

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monticau Co Mo

15. MAIDEN NAME Ella Wood

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monticau Co

17. INFORMANT (ADDRESS) Charles Boyles
California Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Clarksburg DATE 9/34
Masonic Cem

19. FUNERAL DIRECTOR (NAME) (ADDRESS) William R. Popesoy
California Mo

20. FILED 10-3-1940 H. R. Popesoy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-27-1940

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
I last saw h. _____ alive on Never, 19____. Death is said to have occurred on the date stated above, at 4 P m.
The principal cause of death and related causes of importance were as follows:

accidently struck by train no 11 at RR crossing on high in California Mo

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? View Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? accident Date of injury 9-27-1940
Where did injury occur? California Mo
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.
Manner of injury Public Place
Nature of injury RR accident - at crossing
Struck by train no 11

24. Was disease or injury in any way related to occupation of deceased? 5
If so, specify _____
(Signed) H. R. Popesoy Coroner, M. D.
California Mo
(Address) _____

207 \$
30

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.....

NE Williams

Licensed Embalmer No.....

3537

P. O. Address.....

California M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32593**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **571**

Primary Registration District No. **4335-**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Monteagu**
(b) City or town **California**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Ethel Ollie Boyle**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **39** Months **11** Days **24** If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **10-3-40** (b) **H.R. Roper** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **Monteagu**
(c) City or town **California MO**
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **27**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **accidentally struck by train at P.P. crossing on**
at 10:00 AM in California
Due to _____

Due to **Pedestrian**

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **acc**
(b) Date of occurrence **Sept 27 - 1940**
(c) Where did injury occur **California MO**
(City, town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **H.R. Roper** (M. D. or other) _____
Address **California MO** Date signed **10-3-40**

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

SUPPLEMENTAL

