

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

66 0034322
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **FIXED SEP 1 1966** Primary Registration District No. **345** Registrar's No. **69**

VS 300 Rev. 4/59	DATE AMENDED			
10675				
20940				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Mississippi		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Charleston		Length of stay in 1b 3yr	c. CITY OR TOWN Desloge Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Charleston Host House		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Chestnut Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Rosa Middle May Last Voyles			4. DATE OF DEATH Month July Day 20 Year 1966
5. SEX F.	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/15/79
9. AGE (last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) Carter County, Mo.
12. CITIZEN OF WHAT COUNTRY U.S.		13a. FATHER'S NAME Shadrich Chilton	
13b. MOTHER'S MAIDEN NAME Cynthia Coleman		14. NAME OF HUSBAND OR WIFE W. A. Voyles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Ferlyn Prather Cape Girardeau Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral embolism & infarction			30 Min
DUE TO (b) Cerebral arteriosclerosis			3 yrs
DUE TO (c) senile debility			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Phemiplegia, chronic heart disease			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
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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from Sept 1963 to July 20/66 and last saw her ^{him} alive on July 20/66 Death occurred at 2 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE [Signature] (Degree or title)		22b. ADDRESS Charleston Mo	22c. DATE SIGNED 7/29/66 (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/22/66	23c. NAME OF CEMETERY OR CREMATORY St. Francois Mo. pr.	23d. LOCATION (City, town, or county) Bonne Terre, Mo. (State)
24. FUNERAL DIRECTOR C. Z. Boyer & Son Inc. Desloge, Mo. ADDRESS		25. DATE RECD. BY LOCAL REG. 8-29-66	26. REGISTRAR'S SIGNATURE [Signature]

USE BLACK INK OR TYPEWRITER RIBBON

1938

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 B. T. Boyer

Licensed Embalmer No. 3660

P.O. Address Desloge, 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.