M. C. Mill

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

PLACE OF DEATH

County: Pitts

Township: ____ or Village: ____ or City: Sedalia (NO. 314 E Boon St.; ____ Ward)

Registration District No. 668 — File No. 5671

Primary Registration District No. 3032 — Registered No. 26

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Abraham Wesley Boyce

PERSONAL AND STATISTICAL PARTICULARS

SEX: M — COLOR OR RACE: W — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Mar 4, 1841 (Month) (Day) (Year)

AGE: 7 yrs. — mos. — ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Stone Mason 23 H
(b) General nature of industry, business, or establishment in which employed (or employer): 131

BIRTHPLACE (City or town, State or foreign country): Ohio

PARENTS:
NAME OF FATHER: Sam Boyce
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio
MAIDEN NAME OF MOTHER: Sarah Townsend
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amanda Boyce

(ADDRESS) Sedalia Mo

Filed Feb 2, 1915 — A. B. Long, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 2 (Month) — 2 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 1, 1915, to Feb 2, 1915, that I last saw him alive on Feb. 1, 1915, and that death occurred, on the date stated above, at 9:30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Do not know yrs. ____ mos. ____ ds.

Contributory (SECONDARY): Chronic interstitial nephritis

(Duration) Do not know yrs. ____ mos. ____ ds.

(Signed) [signature] M. D.

Feb 2, 1915 (Address) Sedalia Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Crown Hill — DATE OF BURIAL: 2/3/ 1915

UNDERTAKER: Staley & Landis — ADDRESS: Sedalia Mo

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
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CERTIFICATE OF DEATH

PLACE OF DEATH

County .....

Township ..... or Village ..... or City .....

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

(NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(SECONDARY)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS