

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.

PLACE OF DEATH

County Ripley
 Township Jordan
 or
 Village
 or
 City _____ (NO. _____ St. _____ Ward _____)

 MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH
Registration District No. 1090File No. 48179-APrimary Registration District No. 5987Registered No. 4

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

FULL NAME William Boyer

PERSONAL AND STATISTICAL PARTICULARS

SEX

M

COLOR OR RACE

W
 SINGLE
 MARRIED
 WIDOWED
 OR DIVORCED
 (If write the word)
Single

DATE OF BIRTH

Dec81918

AGE

7 yrs. 7 mos. 7 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)

Mo

PARENTS

NAME OF FATHER

George Monroe Boyer

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Mo

MAIDEN NAME OF MOTHER

Fannie L. Crook

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Boyer(ADDRESS) Grandin MoFiled Dec 24 1918

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Dec101918

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I attended deceased from Dec 10, 1918, to Dec 10, 1918, that I last saw him alive on Dec 10, 1918, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH¹ was as follows:Broncho Pneumonia107A91(Duration) _____ yrs. _____ mos. 2 ds.

Contributory

(SECONDARY)

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

(Signed) R. Henry Watson

M. D.

Dec 12, 1918(Address) Grandin 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

Grandin Mo

DATE OF BURIAL

Dec 12, 1918

UNDERTAKER

Martha Boyer

ADDRESS

Grandin Mo

PLACE OF DEATH

County.....

Township.....

or Village.....

or City.....

Registration District No.

File No.

Primary Registration District No.

Registered No.

City..... (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)..... (Year).....		
AGE	If LESS than 1 day..... hrs. or..... min.?	
OCCUPATION		
(a) Trade, profession, or business, or establishment in which employed (or employer)		
(b) General nature of industry, business, or establishment in which employed (or employer)		
BIRTHPLACE		
(City or town, State or foreign country)		

OCCUPATION

(a) Trade, profession, or business, or establishment in which employed (or employer)

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

BIRTHPLACE

(City or town, State or foreign country)

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

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

St. Ward.....

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month)..... (Day)..... (Year).....

I HEREBY CERTIFY, that I attended deceased from

that I last saw h..... alive on....., 191....., to....., 191.....,

and that death occurred, on the date stated above, at....., 191.....,

The CAUSE OF DEATH^r was as follows:

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

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

Contributory

(SECONDARY)

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

(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

UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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