PLACE OF DEATH

County Worth

Township Union
or
Village ~~Parnell Mo~~
or
City _____ (NO. _____ St.: _____ Ward)

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

Registration District No. 904 File No. ~~#~~ 11386

Primary Registration District No. 6215 Registered No. 3

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

FULL NAME Edith Boyd

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (~~Write the~~ word) Widow

DATE OF BIRTH July 11 (Month) (Day), 1846 (Year)

AGE 73 yrs. 6 mos. 11 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work James Wife
(b) General nature of industry, business, or establishment in which employed (or employer) —

BIRTHPLACE (City or town, State or foreign country) Knox Co Ill

PARENTS
NAME OF FATHER James Cox
BIRTHPLACE OF FATHER (City or town, State or foreign country) Kentuckey
MAIDEN NAME OF MOTHER Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Kent.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grey Boyd, (Son)

(ADDRESS) Parnell Mo.

Filed Feb 2, 1920 E. P. Nesbitt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 1 (Month) (Day), 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 27, 1920, to Feb 1, 1920, that I last saw her alive on Jan 27, 1920, and that death occurred, on the date stated above, at 9 20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights

131

150

(Duration) 1 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____

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

(Signed) Egbert Crowson M.D.

Feb 2, 1920 (Address) Parnell

*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 Parnell Mo

DATE OF BURIAL Feb 2 1920

UNDERTAKER ROOF & LAFAVOR

ADDRESS PARNELL MO.

...PHYSICIANS should state ... Exact statement of OCCUPATION is very important. ... in plain terms, so that it may be properly classified.

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

PLACE OF DEATH

County.....

Township ..... or Village..... or City ..... (NO. ..... St.; ..... Ward)

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

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

[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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im-

DATE OF DEATH TO BURIAL