

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

Do not use this space.

27083

1. PLACE OF DEATH

County Howell
Township Sutton
City (No.) (Name) (State) (Ward)

Registration District No. 388
Primary Registration District No. 5542

File No.
Registered No. 5
St. Ward

2. FULL NAME

Cynthia F. Boyles

(a) Residence. No. RD Valley Rd., Mo. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 27 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
12 | 2 | 6

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Impboden Ark
(STATE OR COUNTRY)

10. NAME OF FATHER Chaplin

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) unknown

14. INFORMANT J.C. Payne
(Address) Peace Valley Mo, Rd 1

15. FILED Sept 19 27 H.R. Lynch REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 27, 1927, to Sept 3, 1927, that I last saw her alive on Aug 27, 1927, and that death occurred, on the date stated above, at 11 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS: (into cerebrum)
64 - Cerebral Hemorrhage - Cerebrum
81 - General Arteriosclerosis
92A
97 (duration) yrs. mos. da. ?

CONTRIBUTORY (SECONDARY) 74021 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH. no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Elelandt Bohrer, M. D.
9-3-27, 19 (Address) West Plains, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New Hope Cem. DATE OF BURIAL Sept 7 1927

20. UNDERTAKER J. H. Williams ADDRESS Peace Valley

Carefully supplied. AGE should be stated. SEX should be stated. OCCUPATION is very important. It may be properly classified. Exact state of mind should be stated.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Howell Registration District No. 388 File No.
Township Sison Primary Registration District No. 3342 Registered No. 5-
City (No.) St. Ward)

2. FULL NAME

Cynthia A. Broyles

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-27-1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 2 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. da.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)
15. FILED Sept 4, 1927 J. R. Lynch REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 3 1927

17. I HEREBY CERTIFY, That I attended deceased from to 19....., 19....., and that I last saw him alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

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

REGISTRARS SHALVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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