

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

Do not use this space.

34788

1. PLACE OF DEATH

County.....

Registration District No. **791**

Towship.....

Primary Registration District No. **1003**

City **St. Louis**

(No. **1418 2nd N. Union ave**)

File No.

Registered No. **9920**

St. Ward)

2. FULL NAME

Louella Yates Boyd

(a) Residence. No. **1418 2nd N. Union Ave St.** Ward **6**

(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

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

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

Archie Boyd

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

May 27 1857

7. AGE

70

YEARS

MONTHS

5

DAYS

9

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

At home

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

(c) Name of employer

None

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

10. NAME OF FATHER

James Fielding

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

New York

12. MAIDEN NAME OF MOTHER

Margaret Hoban

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

New York

14.

INFORMANT

(Address)

**Archie Boyd
1418 2nd N. Union**

15.

FILED

NOV - 1 1921

MAILED

Nov 6 Starkloff

REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov 6 1927**

17. I HEREBY CERTIFY, That I attended deceased from **Oct 1926**

....., 19....., to **Nov 6**, 19**27**.
that I last saw b. alive on **Nov 5**, 19**27**, and that death occurred, on the date stated above, at **6 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

**Arterio sclerosis 94A
17**

CONTRIBUTORY (SECONDARY)

several (duration) yrs. mos. da.
Angina pectoris
Two attacks in last month (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) **W. H. Paulay**, M. D.

11/6, 1927 (Address) 1602 Union Blvd.

*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

DATE OF BURIAL

Bellefontaine Cem

Nov 8 1927

20. UNDERTAKER

ADDRESS

W. H. Paulay & Co

**2407
N Grand Blvd**

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.

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

