

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

Do not use this space.

**32978**

**1. PLACE OF DEATH**

County Boone  
Township Columbia  
City Columbia (No. \_\_\_\_\_)

Registration District No. 73  
Primary Registration District No. 3006

File No. 269  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Sarah Elizabeth Boyce

(a) Residence. No. 403 College Ave St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug - 1849

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>80</u>	<u>2</u>		

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

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

10. NAME OF FATHER James J Boyce

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

12. MAIDEN NAME OF MOTHER Eloza O'Rear

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

14. INFORMANT Minnie Boyce  
(Address) Columbia Mo

15. FILED 11-30 19 29 Beatrice Gush  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10 - 29 19 29

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19 29, to \_\_\_\_\_, 19 29, that I last saw her alive on 10-29, 19 29, and that death occurred, on the date stated above, at \_\_\_\_\_, \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS  
arterio sclerosis  
106 B  
97  
112 (duration) 2 yrs. 11 mos. 11 ds.  
CONTRIBUTORY (SECONDARY) Chronic Bronchitis and Asthma  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? sy symptoms  
(Signed) J. A. Morris, M. D.  
10 29 19 29 (Address) Columbia 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 Pokey Fork Boone Mo DATE OF BURIAL 10-30 19 29

20. UNDERTAKER W. J. Wanders ADDRESS Columbia Mo

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

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.

