

WAR 28 1930

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

Do not use this space.

6160

File No. ....  
Registered No. 30 .....  
St. .... Ward

1. PLACE OF DEATH

County St. Francois  
Township St. Francois  
City Farmington, Mo. (No. .... St. .... Ward)

Registration District No. 773  
Primary Registration District No. 6018A

2. FULL NAME Amada Boyer

(a) Residence. No. Cadet, Mo. St. .... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 9 mos. 15 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min. 68 ? ?

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Cadet, Mo. (STATE OR COUNTRY)

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Hospital Records (Address) Farmington, Mo.

15. FILED 2-24-30 T. J. Robinson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-20 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 9, 1927 to 2-20, 1930 that I last saw him alive on 2-19, 1930, and that death occurred, on the date stated above, at 5 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic myocarditis  
93c

CONTRIBUTORY (SECONDARY)

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? clinical

(Signed) P. S. Lane M. D.

2-21-1930 (Address) Hosp. # 4 Farmington, 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

Oldmixon Mo.

DATE OF BURIAL

2/23 1930

20. UNDERTAKER

J. B. Boyer & Son

ADDRESS

Totosi

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.

