

APR 30 1930

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

Do not use this space.

9918

1. PLACE OF DEATH

County Ray Co.
Township Orisk
City (No.)

Registration District No. 743
Primary Registration District No. 5978

File No.
Registered No. 6
St. Ward)

2. FULL NAME

Nelson Lee Boyer

(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. 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 married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 3, 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 5 13

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

9. BIRTHPLACE (CITY OR TOWN) Clay County
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Nelson Reice Boyer

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

12. MAIDEN NAME OF MOTHER Mary Ann Reice

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

14. INFORMANT Susie Iris Cluening
(Address) Orisk Mo

15. FILED Mar 18 1930 L. E. Gallo
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-16 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-19-30 to 3-16-30
that I last saw him alive on 3-13-30 and that death occurred, on the date stated above, at 4 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza with Pleurisy and Robt Pneumonia, Ph Lung.
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (SECONDARY) Pulmonary Abscess
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 11A 108
IF NOT AT PLACE OF DEATH 11A B
DID AN OPERATION PRECEDE DEATH? Plural Effusions
WAS THERE AN AUTOPSY? No with drawn
WHAT TEST CONFIRMED DIAGNOSIS? Robt Lester, M. D.
(Signed) Orisk Mo.
, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Union Cemetery DATE OF BURIAL Mar 17 1930

20. UNDERTAKER C. V. Gibson ADDRESS Orisk Mo

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.

blonds IF
WAP

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SC, AM

blonds
SC

**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 Ray Registration District No. 743 File No.

Township Branch Primary Registration District No. 5978 Registered No. 6

City (No.) St. Ward)

2. FULL NAME

Nelson Lee Boyer

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

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 3 - 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
66 3 13

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)
- (c) Name of employer

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

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. May 8 30 H. G. Ellis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/16 19 30

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

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.

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

19

20. UNDERTAKER ADDRESS

IF B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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