

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

Do not use this space.

Jan 20 1935

358

**1. PLACE OF DEATH**

County Butler  
Township St. Francis  
City (No. ....) St. .... Ward)

Registration District No. 990  
Primary Registration District No. 9133

File No. ....  
Registered No. 1

**2. FULL NAME**

Sylvia Maureen Boyd  
(a) Residence No. .... St. .... Ward. ....  
(Usual place of abode)

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 18 1934

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>3</u>		<u>27</u>	

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) Rice  
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Cecil Boyd

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

12. MAIDEN NAME OF MOTHER Lulla M. Lucas

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

14. INFORMANT M. A. Kelly  
(Address) Roubauer Mo

15. Filed Jan 17 1935 Att. Goll REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 15 1935

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1935, to Jan 15 1935, that I last saw her alive on Jan 10 1935, and that death occurred, on the date stated above, at 11:50 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

acute indigestion  
(duration) yrs. mos. ds. 10 ds.

CONTRIBUTORY (SECONDARY) Rattle Cough  
(duration) yrs. mos. ds. 10 ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF

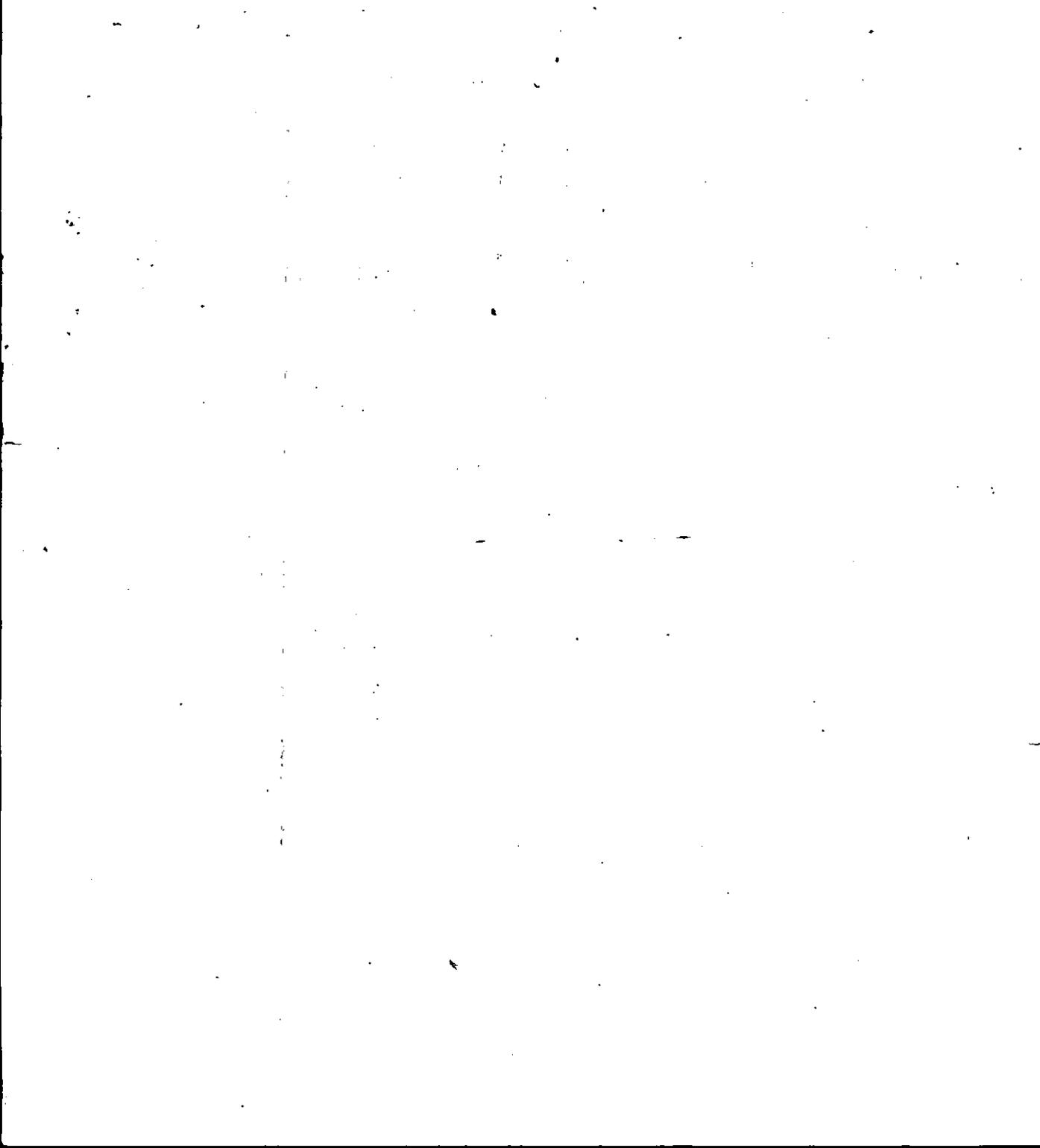
WAS THERE AN AUTOPSY? no  
WHICH TEST CONFIRMED DIAGNOSIS? clinical  
(Signed) J. Deek Howell M. D.

1/14, 1935 (Address) Roubauer 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 Roubauer Cemetery DATE OF BURIAL Jan 15 1935

20. UNDERTAKER C. Owens ADDRESS Roubauer 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.



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Wheeler Registration District No. 490  
 Township St. Francis Primary Registration District No. 5133  
 City (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Lydia Leallen Boyd  
 (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 <u>7</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>5</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>—</u>	<u>2</u>	<u>27</u>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL				
PLACE _____ DATE _____ 19__				
19. UNDERTAKER (ADDRESS)				
20. FILED <u>Jan 14, 1935</u> <u>W. J. Galt</u> Registrar				

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 13, 1935

22. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Acute Indigestion Date of onset \_\_\_\_\_  
Malaria  
 Other contributory causes of importance g

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAR 26 1935

5-35-8